Notes for Community Nursing Providers

Effective July 2021

This current version of the Notes includes provisions for the COVID-19 Pandemic period of 1 April 2020 to 31 December 2021.
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1 Introduction
The Notes for Community Nursing Providers (the Notes) is Annexure A to the Terms and Conditions for the Provision of Community Nursing Services (Terms and Conditions).

The Notes form part of a legally binding Agreement setting out the conditions and accountability requirements under which Community Nursing (CN) providers may provide services to clients under Department of Veterans’ Affairs (DVA) health care arrangements. The CN provider and all personnel delivering CN services to clients must read, understand and comply with the Notes, which are non-negotiable.

The DVA Community Nursing Schedule of Fees (Schedule of Fees) is Annexure B to the Terms and Conditions. The set fees within the Schedule of Fees compensate a CN provider for the costs associated with the provision of CN services during a 28-day claim period. The cost components covered by the fees for the provision of CN services are:

- face-to-face time;
- travel time;
- general time;
- labour on-costs;
- overheads;
- profit margin; and
- ‘nurse’s toolbox’ consumables.

Indexation applied to the Schedule of Fees takes effect for claim periods commencing on or after the date indexation is applied.

DVA has a commitment to innovation and continuous improvement of its activities and consults with a broad range of organisations within the CN field as required.

To remain contemporary with changes in the CN field, the Notes may be amended from time to time. DVA will publish updated versions of the Notes on AusTender, and on the DVA website at: https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing

This current version of the Notes includes provisions for the COVID-19 Pandemic period of 1 April 2020 to 31 December 2021.

1.1 Services and payments
DVA will pay for CN services delivered to a DVA Veteran Card (Gold Card or White Card) holder (entitled person) by an approved CN provider. There may be occasions where a CN provider will be asked to provide services to an entitled person without Veteran Card eligibility. See Section 3.1.4 Clients without a Veteran Card for more information.

For the purposes of the Notes, entitled persons will be referred to as clients.
1.1.1 Changes to service delivery areas or sites
A CN provider will supply DVA with information related to changes to service delivery areas or sites within a reasonable timeframe. This is considered part of administrative information required by DVA. See clause 12 Provision and Disclosure of Provider Information in the Terms and Conditions for more information.

1.1.2 Subcontracting
CN providers intending to utilise the services of subcontractors are required to:

- notify DVA by completing the subcontracting template within 14 days in the event of any subcontractor being used to deliver CN services to clients. The template can be found at: Information for community nursing (CN) providers (dva.gov.au);
- identify subcontractors by providing their legal name, ABN, ACN and registered or principal place of business;
- allow DVA to view and authorise the terms of any subcontract as requested;
- ensure that subcontractors employ suitably qualified personnel to deliver services, as per the requirements set out in Section 5 Personnel;
- ensure that subcontractors have access to the Notes and any other DVA material required for them to deliver services in accordance with DVA requirements;
- inform subcontractors about obligations outlined in the Agreement with DVA. In providing services, subcontracted service providers are expected to be made aware of and comply with the DVA Service Charter;
- ensure the continuing suitability of subcontractors, including compliance with law generally and anti-discrimination laws;
- ensure that no subcontract restricts DVA’s legal rights; and
- appropriately pay or reward subcontractors under any relevant subcontract, including accounting properly for all tax-related issues.

1.2 Provider number/s
DVA allocates CN providers with a provider number/s for claiming and monitoring purposes. Generally provider number/s are allocated as follows:

- one provider number will be allocated if all services are delivered within the same State or Territory; or
- a provider number will be allocated for each State or Territory if services are delivered in multiple States or Territories.

Organisations requiring additional provider numbers for specific sites for organisational business purposes are requested to email the DVA contract manager at NMBCN@dva.gov.au.
1.3 Access to the Notes
A CN provider must ensure that all of its personnel and subcontractors delivering CN services to clients have access to, and a working knowledge of, the current Notes, including any amendments made to the Notes over time.

1.4 Contacting DVA
A CN provider can contact the DVA Provider Enquiry Line by telephone on 1800 550 457.

Written enquiries can be emailed to:
- for general interpretation/clarification of program policies contained in the Notes: nursing@dva.gov.au
- for matters relating to the contract: NMBCN@dva.gov.au
- for client eligibility checks: Health Approvals at health.approval@dva.gov.au (or via phone on the provider enquiry line above).

Information about the CN program can be found online at: https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing.

1.5 Complaints mechanism
A CN provider can make a complaint about any aspect of the CN program by emailing feedback@dva.gov.au or online at Complaints, compliments and other feedback

DVA will review all complaints and inform the CN provider of the outcome.
2 Aims of the Community Nursing program

2.1 DVA health services
DVA provides clients with access to a range of quality health care and related services, including CN services, at DVA’s expense.

Information about all of DVA’s services, including the CN program, can be found online at: https://www.dva.gov.au

2.2 Community Nursing program
The aim of DVA’s CN program is to enhance the independence and health outcomes of a client and avoid early admission to hospital and/or residential care through the provision of CN services that meet the client's assessed nursing needs. Nursing services include both clinical and personal care services which work together for a defined health outcome. DVA enables this by contracting CN providers to deliver nursing services to clients in their own home. The CN program is not designed to deliver a high level of nursing interventions, nor be a substitute for a fulltime carer or a respite service. Similarly, the CN program is not a hospital substitution service or part of a hospital substitution service.

Community nursing can be defined as a primary care service that aims to support the general health of a patient with low risk, simple clinical interventions.

CN services are delivered by a skills mix of Registered Nurses (RN), Enrolled Nurses (EN), and Personal Care Workers (PCW), also known as nursing support staff.

A CN provider must:
- deliver CN services in line with industry recognised evidence based best practice and CN industry standards; and
- assist a client to develop, increase or maintain their independence, health and wellbeing.

A person with significant care requirements, for example requiring 24 hour care, may not be considered independent. Many of the tasks and activities required to meet significant care needs are not classified as nursing services and are instead performed by a carer or for the purposes of respite (giving the carer a break or relief from caring responsibilities).

Where a client is identified as having significant care needs, for example through an Activities of Daily Living (ADL) assessment, the most appropriate care setting should be considered, particularly if carers are not available to provide the necessary care. Clients with a high level of nursing care needs long term may not be suitable for CN services. Consideration should include whether the person is most appropriately cared for in a health care or residential aged care setting, where a range of therapeutic services can be provided, ultimately resulting in better health and wellbeing outcomes for the client.
2.3 Out of scope/Exclusions
Where clients are receiving similar services through another program, there should be no duplication of services between the programs.

The CN program does not provide in home respite care, or provide services to meet needs associated with Instrumental Activities of Daily Living (IADLs). Where ADLs and IADLs are assessed through one tool, only the ADLs should be supported through the CN services. IADLs can be supported through DVA’s Veterans’ Home Care program.

CN services are based on maintaining a person’s independence at home, and should complement rather than replace services that are more appropriately delivered through another program or by a carer.

2.3.1 Hospital substitution services
Hospital substitution services, including Hospital in the Home, are out of scope for the CN program. These services require more specialised arrangements than those typically provided through a primary care service such as the CN program.
3 Accessing the Community Nursing program
3.1 Eligibility
A client is a person to whom DVA has issued a:

- Veteran Card — All Conditions within Australia, or Totally & Permanently Incapacitated (TPI) (Veteran Gold Card); or
- Veteran Card — Specific Conditions (Veteran White Card).

In the majority of cases, to be eligible to receive CN services for an assessed nursing care need, a client must hold either a Veteran Gold Card or a Veteran White Card.

There may be instances where a client is approved for CN services but they are not eligible for a Veteran Card. See Section 3.1.4 Clients without a Veteran Card for more information.

3.1.1 Veteran Gold Card
The Veteran Gold Card is gold in colour and includes the words:
“Veteran – All Conditions within Australia” OR
“Veteran – Totally & Permanently Incapacitated”.

A Gold Card enables a client to receive health care and related services to meet all of their assessed clinical nursing and/or personal care needs, regardless of whether they are war or service related.

3.1.2 Veteran White Card
The White Card is white in colour and includes the words:
“Veteran – Specific Conditions”.
For all Veteran White Card holders, the CN provider must contact DVA to determine eligibility to receive CN services for an assessed clinical nursing and/or personal care need prior to the commencement of CN services. See Section 1.4 Contacting DVA. CN services can only be provided to meet care needs associated with the client’s accepted condition/s.

3.1.3 Veteran Orange Card
The Veteran Orange Card is orange in colour and includes the words “DVA Health Card – Pharmaceuticals Only”.

The Veteran Orange Card is for use only for pharmaceuticals and wound dressings through the Repatriation Pharmaceutical Benefits Scheme (RPBS) for eligible Commonwealth and Allied veterans and mariners.

It cannot be used to access any CN services.

3.1.4 Clients without a Veteran Card
In some cases, a CN provider may be required to provide care to a client with multiple or complex needs and who does not have a Veteran Card.
Before services commence, DVA will contact a CN provider to formally request services for the client and confirm the agreed method of payment.

3.2 Referrals
A CN provider cannot deliver CN services to a client without a valid referral from an authorised referral source.

A written referral for a client must be received from one of the following authorised referral sources:

- General Practitioner (GP);
- Treating doctor in a hospital;
- Hospital discharge planner; or
- Nurse Practitioner specialising in a CN field.

Note: The client’s GP to have ongoing clinical oversight of the person’s care.

Referrals should outline necessary services to meet an assessed nursing care need for a medical condition. The required nursing, that is clinical and personal care interventions, should be included in the referral.

Referrals are valid for 12 months, at which time a new referral is required.

A Veterans’ Home Care (VHC) Assessment Agency may identify a need for CN services and refer the client to their GP for a CN referral. The VHC Assessment Agency will provide the client with a copy of their VHC assessment to share with their GP. With the client’s consent, the VHC Assessment Agency can send a copy of the VHC assessment directly to the client’s GP with a recommendation the client may require a referral for CN services.

If DVA establishes that a CN provider has given or offered financial or other inducement to any authorised referral source to generate referrals, it may terminate its Agreement with the CN provider and take any further action available under the Terms and Conditions of the Agreement.

As such, a CN provider cannot represent itself in any way as a DVA preferred provider.

3.2.1 Written referral requirements
The authorised referral source must provide a written referral for a client to request CN services. The referral should be on the referral source’s official letterhead or CN provider’s official referral form, and sent directly to the CN provider.

The referral must include the following information:

- authorised referral source’s details, including provider number (for a referral from a discharge planner or treating doctor in a hospital, the hospital’s provider number must be used);
• the medical condition/s the client requires CN services for, and clinical details of the condition including recent illness and injuries;
• if medication administration or assistance is required, a medication authority or signed current medication chart / list that includes medication information;
• a measure of the person’s level of independence. If the level of independence has not been included in the referral, the RN should assess this as part of the initial comprehensive assessment, using an industry recognised measure of assessing independence. The tool should include ADLs such as showering, grooming, dressing, bowel and bladder care, transfers and mobility. If assistance with eating to meet a clinical need is determined, a nutritional assessment must also be conducted to determine the nutritional risk; and
• whether an aged care assessment has been conducted by an Aged Care Assessment Team (ACAT) assessor, and the outcome of the assessment. If an assessment has not been conducted, the CN provider should facilitate one within the first 28 day claim period.

3.2.2 Referrals from hospitals
Where a referral is received from a hospital (treating doctor or discharge planner) following a client’s stay in hospital, the referral is valid for a period of seven days post discharge. An updated referral is required from the client’s GP to cover ongoing care needs beyond the seven day period.

As a person may have higher care needs in the post-hospitalisation period, consideration should be given to whether the client’s care needs immediately following discharge could be better met through a program such as DVA’s convalescent care program; or the Department of Health’s Transition Care Programme or Short-Term Restorative Care Programme. A CN provider should discuss the most appropriate program / service for clients with the hospital discharge planner prior to accepting a referral. Information about DVA’s convalescent program is available on the DVA website at Convalescent care | Department of Veterans’ Affairs (dva.gov.au). See Section 13.5.8 Transition Care Programme, and Section 13.5.9 Short-Term Restorative Care Programme for further information.

3.2.3 Referral to a CN provider
An authorised referral source should refer a client to a suitable CN provider in the same geographic region as a client’s place of residence. Providers can be identified from the panel located on the DVA website at: https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing/panel-community-nursing

The panel is arranged by Service Delivery Areas and Local Government Areas for each State and Territory.

In some circumstances a suitable provider may not be the closest geographic provider, for example where the closest provider doesn’t have capacity to provide the required services.
3.2.4 Referral Period
A referral is valid for a period of 12 months, or if a client is admitted for less than 12 months is ongoing through the client’s episode of care, from admission to discharge. A new referral from the client’s GP will be required if a client is transferred to another CN provider, discharged and later readmitted, and at the end of every 12 month period where ongoing services continue to be required.

3.2.5 Informal enquiry
An informal enquiry may be received from a number of sources, such as a verbal enquiry from a client, a family member or a concerned neighbour.

If an informal enquiry is received, the CN provider must advise the person to contact the client’s GP (or another authorised referral source), to obtain a written referral. The written referral is required prior to the commencement of CN services.

3.2.6 Acceptance of a referral
A CN provider should accept a referral for a client from an authorised referral source, including following the transfer of a client.

A referral cannot be refused by a CN provider without first notifying DVA and indicating the reasons for refusal. DVA will determine if the referral can be refused. The economic viability of caring for a client is not a criterion for refusing a referral. The referrer should be notified verbally and in writing immediately if the referral will not be accepted.

3.3 Transfer of a client
A CN provider cannot transfer a client to another CN provider due to capacity or other contractual reasons once services have commenced unless approval is granted by DVA. Where this is the case, the contract manager should be contacted – see Section 1.4 Contacting DVA.

An agreed transfer plan must be in place before any transfer, including agreed wording and approach for notification to the client. The CN provider is required to support a smooth transfer without disruption to a client.

Where a client transfers to another CN provider, e.g. due to client choice or moves to another location, the transfer can take place with the oversight of the client’s GP. There must be no disruption to the client’s services.

A new referral from the client’s GP will be required if a client is transferred to another CN provider.

3.4 Informed consent
A CN provider must obtain written informed consent from the client before commencing CN services. If the client is unable to give their consent, a person who is legally authorised to give substitute consent for services under State or Territory law (e.g. The Public Trustee, Guardian, a holder of an
appropriate Enduring/Special Power of Attorney, etc.) may consent on their behalf.

To ensure the client has information to make an informed choice about the proposed CN services, the CN provider must inform them of:

- the proposed CN services to be delivered in written format, and supported by a verbal explanation;
- their rights and responsibilities as the client;
- the role of the CN provider’s personnel, and that different personnel may be providing CN services, as clinically appropriate;
- the possibility that the CN provider’s personnel may be required to disclose personal information about them to other health providers, as clinically appropriate, and in some instances without seeking the client’s consent prior to the disclosure;
- the right of DVA, or any person or organisation authorised by DVA, to access all of the records held by the CN provider, including their care documentation; and
- the process for providing feedback or making a complaint about the CN services that they receive.

3.5 Date of admission
The date of admission is the first face-to-face contact visit between a CN provider’s personnel and the client. This first face-to-face contact visit must include a comprehensive assessment undertaken by an RN, in the client’s home.
4 Care environment
The care environment for DVA funded CN services is the client’s own home.

A CN provider must:
• deliver all CN services to a client face-to-face in their place of residence;
• deliver CN services in accordance with the nursing care plan; and
• provide a contact for clients for emergency purposes 24 hours a day, 7 days a week.

A CN provider cannot deliver CN services to a client in any of the following locations:
• an acute facility (including hospital in the home programs);
• a residential aged care facility;
• a multi-purpose centre;
• a community centre; and/or
• a clinic in any location.

If a client chooses to access, or a CN provider chooses to deliver, services in a facility or clinic instead of the client’s place of residence, then the CN provider cannot claim for payment for these services from DVA.

During the COVID-19 pandemic period of 1 April 2020 to 31 December 2021, where face-to-face services cannot be delivered and it is clinically appropriate to do so, these services may be delivered remotely, such as by telephone or online. Services that are delivered remotely can be claimed using the normal Schedule of Fees items. The remote delivery of services during a 28 day claim period may be claimed from 20 March 2020.
5 Personnel
A CN provider may use a mix of personnel to deliver CN services. These personnel include:
- Registered Nurses (RN);
- Enrolled Nurses (EN); and
- Personal Care Workers (PCW).

All personnel must be considered fit and proper persons to work with DVA clients.

When delivering CN services, all personnel must work within the framework of the relevant national standards and meet all State/Territory and Commonwealth statutory requirements.

CN providers must maintain current registration and continuing education documentation for all their personnel; and ensure that all personnel and sub-contractors who have access to clients have had a national police check within the last three years, and hold a working with vulnerable persons certificate / clearance or State / Territory equivalent.

CN providers must ensure services are delivered in a safe, effective and responsive manner to facilitate positive outcomes for clients. Services should be delivered in a suitable environment that promotes dignity, integrity and a respect for cultural and linguistic diversity and social differences.

5.1 Registered Nurses (RN) and Enrolled Nurses (EN)
The national standards developed by the Nursing and Midwifery Board of Australia (NMBA) provide the framework for professional nursing practice in Australia.

All CN services delivered by RNs and ENs must be in accordance with the national standards. Information on the national standards for RNs and ENs can be accessed online through the ‘Professional Codes and Guidelines’ tab, at: www.nursingmidwiferyboard.gov.au/

5.2 Personal Care Workers (PCW)
The Community Services Training Package developed by the Community Services and Health Industry Skills Council forms the training and assessment framework for the certification of PCWs (also known as nursing support staff).

All CN services provided by PCWs must be in accordance with the relevant standards and qualifications set out in the Community Services Training Package.

Information about the Community Services Training Package can be accessed online at: https://training.gov.au/Training/Details/CHC
5.3 Qualifications and competencies

5.3.1 Registered Nurses (RN) and Enrolled Nurses (EN)
The minimum required qualifications and experience for RNs and ENs delivering CN services to a client are:
- current national registration with the Australian Health Practitioner Regulation Agency (Ahpra) with no restrictions to practice;
- a minimum of three years’ experience working as an RN or EN in the CN field;
- manual handling competency; and
- current Cardiopulmonary Resuscitation (CPR) certification.

Qualifications and competencies must be maintained and recorded in personnel files.

Suspension of 3 Year Experience Rule for RNs and ENs during the COVID-19 Pandemic Period (1 April 2020 to 31 December 2021)
Taking into consideration workforce pressures, DVA has approved the temporary suspension of the three years’ experience requirement for RNs and ENs. This has been supplemented with the ability to use RNs and ENs who have had one year supervised post-registration practice. CN providers will be responsible for appropriate supervision, training and support of these employees.

5.3.2 Personal Care Workers (PCW)
The minimum required qualifications and experience for PCWs delivering CN services to a client are:
- a Certificate III in Home and Community Care, Aged Care or Disability (pre December 2015); or Certificate III in Individual Support (post December 2015). This includes a medication module for PCWs to provide assistance with medication that is recognised by the Community Services Health Industry Skills Council;
- a minimum of three years’ experience working in a PCW role in the CN field;
- manual handling competency;
- current Cardiopulmonary Resuscitation (CPR) certification; and
- a current Applied First Aid certificate (refer below).

These competencies must be maintained and recorded in personnel files.

Employment of Student Nurses as Personal Care Workers during the COVID-19 Pandemic Period (1 April 2020 to 31 December 2021).
Taking into consideration workforce pressures, DVA will allow CN providers to employ second or third year university nursing students to provide personal care services. CN providers will be responsible for appropriate supervision, training and support of these employees.

5.3.3 First Aid and CPR requirements
Personnel’s First Aid certificates must be:
- current;
• from a registered training organisation; and
• the CPR component of the First Aid certificate must be maintained on an annual basis through a recognised training organisation. Refer to the Australian Resuscitation Council link: https://resus.org.au/.

Re-certification and assessment training requirements during the COVID-19 Pandemic Period (1 April 2020 to 31 December 2021)
If re-certification or assessment requirements for First Aid and CPR fall due, and online options are not available, DVA may grant a temporary exception to the personnel re-certification requirements. CN providers, on behalf of the relevant personnel, must seek approval from DVA for any exception. Personnel who have been granted an exception under this provision will be required to complete the relevant re-certification or assessment as soon as practicable.

Infection control training requirements during the COVID-19 Pandemic Period (1 April 2020 to 31 December 2021)
The Department of Health (DOH) has developed an Infection Control training module for use by care workers across the health, aged care, disability and childcare sectors. This training can be accessed at: https://covid-19training.com.au
All DVA CN providers must ensure that all Personnel undertake this training. DVA must be notified once this has been completed by emailing: nursing@dva.gov.au

5.3.4 Delegation of care
A CN provider must ensure that all CN services delivered by an EN and/or PCW are planned, delegated, supervised and documented by an RN. All delegated care must be appropriately documented in clinical records and kept on the client’s file.

The RN must recognise the differences in accountability and responsibility between RNs, ENs and unlicensed care workers (i.e. PCWs). An RN must delegate aspects of care to others according to their competence and scope of practice. This includes:
• delegation of aspects of care according to role, functions, capabilities and learning needs;
• monitoring aspects of care delegated to others and providing clarification/assistance as required;
• recognising own accountabilities and responsibilities when delegating aspects of care to others; and
• delegation to and supervision of others consistent with legislation and organisational policy.

5.3.5 Continuing education for personnel
The CN provider must ensure its personnel have access to, and undertake, appropriate continuing education and professional development, particularly in relation to the provision of CN services, on a regular and on-going basis.

The CN provider must maintain current education and professional development records for all its personnel. This is in line with the Australian Health Practitioner Regulation Agency (Ahpra) Standards for Nursing. More information can be found at the following link: [www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx](http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx).
6 Assessment

An RN must assess the nursing care need/s of a client through a comprehensive assessment. As is the case for all CN services, assessments occur face-to-face in the client’s home. Assessments must be undertaken:

- upon receiving a referral from an authorised referral source;
- following transfer from another CN provider; and
- on a 12 month anniversary from the commencement of care (if there have been 13 consecutive 28-day claim periods) when a new referral is received from the client’s GP.

A comprehensive assessment includes the use of validated assessment tools based on current CN industry best practice standards.

Where an assessment of the person’s level of independence has not been included in the GP referral, this should be conducted as part of the initial comprehensive assessment using an industry recognised measure including ADL tool.

There must be an assessed clinical need for clinical nursing care for CN services to be provided to a client. Where an assessment is undertaken and no ongoing care needs are identified, the CN provider must use the Assessment only – no ongoing services item number (NA99) for claiming.

The outcomes of each comprehensive assessment will inform the development of a new nursing care plan. The RN must report the outcomes of each comprehensive assessment to the client’s GP. Where the GP is not the original referral source and ongoing services are required, an updated referral will need to be provided by the GP. See Section 3.2 Referrals for further information.

Clinical nursing notes and assessment documentation must remain up-to-date and be based on current CN industry best practice standards.

6.1 Assessment of personal care needs

When a client is assessed as requiring low level personal care services up to and including 1.5 hours per week and the client does not have a clinical need for any other CN services, the personal care services should be provided through the Veterans’ Home Care (VHC) Program. The CN provider should refer the client to a VHC Assessment Agency on 1300 550 450, and advise the authorised referrer of the outcome.

When a client is assessed as requiring low level personal care services up to, and including, 1.5 hours per week and the client has a clinical need for CN services, all of the personal care services required should be provided through the CN program.
6.2 Nursing care plan
Following the comprehensive assessment, the RN is required to identify and document within a nursing care plan:

- clinical and personal care needs identified from the comprehensive nursing assessment;
- client’s level of / capacity for independence;
- client’s agreed goals and actions (short and long term objectives);
- identified clinical and home related risks;
- clinical care intervention/s consistent with best practice and evidence;
- personal care interventions consistent with best practice and evidence;
- expected outcomes of care;
- delegation of care within Scope of Practice as per Section 5.3.4 Delegation of care;
- review dates; and
- agreed days and timeframes that services will be delivered.

The assessment should also identify any Allied Health or community services that are required, for example occupational therapy, delivered meals, etc., and a request made to the GP to arrange referrals as appropriate.


Business continuity plans
It would be expected CN providers have business continuity plans covering aspects including ensuring continuity of service delivery and access to personal protective equipment (PPE) as required.

Individual pandemic plans
The assessment fee item (NA02) can be claimed to develop individual COVID-19 pandemic plans for DVA CN clients.

The development of an individual pandemic plan can be conducted by the most appropriately qualified staff member. For example, if a client is receiving majority clinical care, the pandemic plan would be developed by an RN or an EN, whereas if a client is receiving personal care only, this plan may be developed by a PCW. Plans developed by an EN or PCW would need to be reviewed and authorised by an RN.

Where possible, it is preferable that the plan is developed in a face-to-face assessment visit with the client and their family or carer. DVA expects CN providers to produce a physical plan that is kept at the client’s home and is accessible to the client, their family or carer and others as required. The plan should also be signed by the client or their representative.

CN providers may need to undertake follow up activities to ensure any actions or supports are in place or can be actioned quickly. These follow up activities can either be conducted at the client’s home or from the CN provider’s office. Follow up activities may include: typing up and printing the plan; showing clients how to order groceries online or arranging the
home delivery of medicines; organising other services such as Veterans’ Home Care (VHC) or meals on wheels; or talking to neighbours or alternative carers / supports about what support they can provide. In some instances, carers or other natural supports may need to be shown what to do.

DVA considers these follow up activities to fall under the personal care classification in the Schedule of Fees. It is not anticipated that the follow up activities would take more than the equivalent of three visits.

**Plan Considerations and Inclusions**

When developing the plan, the following should be considered:

- the client’s essential and non-essential care requirements;
- CN services that can be delivered remotely, for example clinical wellbeing checks and medication prompting;
- other services that may help prevent clinical or health deterioration, for example meals on wheels, grocery delivery, off-site laundry services, VHC, DVA transport services;
- whether neighbours, friends or family could provide assistance in the event of a disruption to services; and
- how the client will access medications and/or consumables items such as continence products.

The actual physical plan should include:

- a contact list - for your agency, the client’s general practitioner, their pharmacist, informal community supports such as neighbours, any other service providers including grocery stores, as well as the National Coronavirus Helpline – 1800 020 080, and the client’s next of kin or other nominated contact person;
- how they will be advised if there is a disruption to your services; and
- an indicative service schedule should the plan be triggered including how each service will be delivered, e.g. remotely, in-person, by a neighbour or family/carer.
7 Classification
A CN provider must classify a client under the appropriate Classification System.

The Classification System is based on:
- an episode of care model where a provider retrospectively claims for payment at the end of each 28-day claim period; and
- groupings of visit types in three separate schedules:
  - Clinical Care (core and add-on);
  - Personal Care (core and add-on); and
  - Other Items.

Figure 7.1 on page 36 demonstrates some examples of core, opposing add-on schedule and Other Items add-ons.

Clinical and Personal Care Core, Add-on and Second Worker items may be claimed for up to 84 visits per claim period, where a client requires up to three visits per day throughout a 28-day claim period.

7.1 Majority of care principle
A CN provider will classify a client into either the Clinical Care schedule or the Personal Care schedule, whichever is the core care requirement (majority of care principle).

Majority of care is generally based on visit count, although there are situations when time may represent the majority of care.

Where equal time and visits has been spent on clinical and personal care, the client should be classified under the Clinical Care schedule.

7.2 Combinations of care
The Classification System allows for combinations of care, for example:
- if the majority of care classification is from the Clinical Care schedule – a Personal Care schedule add-on can also be claimed if personal care is delivered; or
- if the majority of care classification is from the Personal Care schedule – a Clinical Care schedule add-on can also be claimed if clinical care is delivered.

If any other CN services or nursing consumables are also provided, item numbers from the Other Items schedule may also be claimed.

7.3 Clinical Care schedule
Clinical care is defined as clinical nursing care required to treat medical conditions.

The goal of clinical care is to maintain the client’s optimal health status through interventions that have a clinical purpose, including regular review of care needs to determine if improved outcomes have occurred. Clinical care
must be delivered by RNs or ENs (based on their qualifications and experience).

Where a client is in a palliative phase, palliative care add-ons may be claimed to support the psycho-social elements of care being provided under the Clinical Care schedule. Palliative care provided by a CN provider must be under the supervision of the relevant specialist palliative care team.

DVA expects that once the goal/s of care has/have been achieved and the client’s condition/situation is stable, a discharge plan will be implemented.

There are three classifications in the Clinical Care schedule. They are:
- Clinical (Short Term) Support;
- Clinical (Short or Long); and
- Post-Operative Eye Drops.

7.3.1 Clinical support
The Clinical Support visit type is used when the client requires no direct treatment for a medical condition, however there are nursing interventions required to support health outcomes. These could include coordination, health education and goal setting, monitoring, and is based on an identified clinical need that is definable and has expected health outcomes.

Clinical Support is a short-term classification and can only be claimed for a maximum of three 28-day claim periods per six months of continuous care.

Clinical Support aims to prevent health complications and/or deterioration in health status by providing services such as:
- coordination of care between allied health professionals and the GP to ensure all required appropriate services and equipment are in place;
- education including clinical advice related to self-management of medical conditions (medication use, safety and falls risks, chronic disease management), goal setting, self-monitoring, risk management and early recognition of deterioration; and/or
- monitoring of an unstable health condition requiring reporting to the GP (reportable levels from the GP must be obtained if performing short term Blood Glucose Levels (BGL) or Blood Pressure (BP) monitoring).

The Clinical Support visit type is not to provide a check visit for a client who is:
- stable in health (including has a stable BGL or BP); or
- self-reporting (client or carer able to contact/visit GP if issues arise).

If a client is a participant of the Coordinated Veterans’ Care (CVC) Program, and a practice nurse is the care coordinator, CN providers must ensure there is no duplication of services with the Clinical Support visit banding.

If a client is a CVC Program participant and care coordination is being delivered via a CN provider, Clinical Support cannot be claimed while the client remains enrolled in the CVC Program.
7.3.2 Clinical (short or long)
There are two visit lengths in the Clinical visit type. A client can be classified as:
- Clinical Short (20 minutes or less) with nine categories of visit range, or
- Clinical Long (21 minutes or more) with six categories of visit range.

The Clinical item number must correspond with the visit length and the visit range (number of visits provided) in the 28-day claim period.

7.3.2.1 Mix of short and long visits
Where there is a mix of short and long visits provided in a 28-day claim period, the CN provider calculates the total minutes of clinical care and divides this by the number of clinical care visits provided to determine the correct classification (short or long) to be claimed.

7.3.2.2 Medication administration – clinical care
The client must be classified under the Clinical Care schedule and the care must be provided by an RN or EN with an approved qualification in administration of medications if the client requires the administration of:
- prescribed medications (Schedule 4 and above);
- Schedule 8 drugs if dispensed from a bottle/packet, including Schedule 8 transdermal patches;
- prescribed medicated eye drops (Schedule 4 and above); and/or
- prescribed creams.

Where a client is assessed as requiring medication administration or assistance with medication, the care interventions should be documented in the medication management section of the nursing care plan for each prescribed dose and time of administration as documented on the medication authority or signed medication chart by the prescribing / referring doctor.

7.3.2.3 Symptom management
When a client is referred to the CN program for symptom management for an unstable disease/condition they must be classified under the Clinical visit type (NL03 to NL29 in the Schedule of Fees) – not Clinical Support.

Symptom management requires a GP or specialist to give a diagnosis, orders regarding a treatment plan, and medication orders.

If a client is stable in their condition/chronic disease or palliative care phase, they must be classified under Clinical Support with a plan for discharge.

7.3.3 Post-operative eye drops
This visit type is specifically for eye drop administration, prescribed by a specialist, following eye surgery. There must be 85 or more visits within the claim period to claim this item number.
The Post-Operative Eye Drops visit type:
- can be claimed only once per eye, for one 28-day claim period per 365 days; and
- is based on a minimum of over three visits a day for the 28-day claim period.

Any prescribed eye drops of a continuous nature (i.e. longer than one 28-day claim period) must be classified in the Clinical or Personal Care schedules, depending on the type of eye drops required and any other clinical and/or personal care intervention/s provided to the client.

PCWs cannot provide Post-Operative Eye Drops services but can be used to deliver personal care services, if this intervention is also required.

7.4 Personal Care schedule
A CN provider will classify a client into the Personal Care visit type when personal care is the core care requirement for CN services.

The goal of personal care is to support the clinical outcomes of a client so that they can remain independently at home as long as possible.

Personal care is generally considered a time limited (for example following surgery) or specific intervention to provide assistance with ADLs. ADLs include:
- Personal hygiene (bathing, grooming, oral and hair care);
- Continence management;
- Dressing;
- Assistance to eat (which may include heating a meal). This must meet a clinical need if provided through the CN program, and a nutritional assessment would be required to identify nutritional risk; and
- Mobility / transfer (walk with assistance / move from one position to another manually or with assistance, e.g. mechanical lifter).

Personal care is not considered to be any person to person support. If the person’s level of independence has not been included in the GP referral, the level of independence should be assessed using an industry recognised, validated tool in the initial comprehensive assessment by the RN.

Care needs relating to IADLs are outside the scope of the CN program. If a care need relating to an IADL is identified, the person can be referred to a Veterans’ Home Care (VHC) Assessment Agency for assessment. Additional care needs outside the scope of the CN program may also be covered under another suitable program such as the Home Care Packages (HCP) Program or Commonwealth Home Support Programme (CHSP). The client can be referred for an Aged Care Assessment from an ACAT assessor.

IADLs include:
- companionship and emotional support;
- transportation;
• cleaning / dishwashing;
• routine laundry;
• shopping;
• childcare in some short-term and crisis care circumstances;
• lawn mowing;
• gardening;
• cleaning gutters;
• meal preparation;
• arranging for medications and filling prescriptions;
• communicating with others; and
• managing finances.

Where there is a hygiene related risk to a client’s health status, essential assistance with laundry to mitigate the clinical risk may be provided.

Where a client is in a palliative phase, personal care requirements to meet clinically required care needs can be provided under the personal care schedule, in conjunction with any clinical care requirements provided through the clinical care schedule.

Personnel used to deliver Personal Care services include RNs, ENs and PCWs. However, the CN provider must ensure that all CN services delivered by ENs and PCWs are planned, delegated and supervised, and documented by an RN in the nursing care plan, in line with requirements in Section 5.3.4 Delegation of care.

A client will be classified within the Personal Care schedule according to the visit range and, if applicable, the visit length. There are three visit lengths that apply to the Personal Care schedule for number of visits over 35. The visit lengths are:
• Short - up to 30 minutes per visit;
• Medium - 31 to 45 minutes per visit; and
• Long - 46 minutes or more per visit.

Clinical Wellbeing Checks for the duration of the COVID-19 Pandemic Period (1 April 2020 to 31 December 2021)
CN providers are able to claim for remote clinical wellbeing checks during the COVID-19 pandemic. DVA recognises monitoring clients’ clinical wellbeing occurs naturally through regular face-to-face services. Due to a reduction in services as a result of workforce shortages or a client refusing services, this monitoring should continue. For this reason CN providers can claim for remotely delivered clinical wellbeing checks such as daily or regular telephone calls. This can be claimed through the regular Schedule of Fees under the personal care classification.

7.4.1 Personal care – mix of visit lengths
A client may require a mix of short, medium and long Personal Care visit lengths in a 28-day claim period.
Where there is a mix of short, medium and long visits in a 28-day claim period, the CN provider calculates the total minutes of personal care provided and divides this by the number of personal care visits provided to determine the correct visit length classification (short, medium or long).

7.4.2 Assistance with medication
A client can be assisted with self-administered medication by PCWs under the following criteria:

- the client’s medical condition/s is/are stable; and
- there is an established medication regimen; and
- there is a nursing care plan in place which includes medication contraindications (interactions and side-effects) and emergency contacts; and
  - there is a blister pack filled by a registered Pharmacist which meets the DVA Dose Administration Aid service requirements; or
  - it is over-the-counter medication, or prescribed/non-prescribed cortisone cream; and
- the PCW;
  - has completed the required assistance with medication administration competencies recognised by the Health Industry Skills Council; and
  - adheres to the relevant Commonwealth and State/Territory Drug Acts; and
  - adheres to the CN provider’s Medication Administration/Prompting Policy/ies; and
- personnel adhere to the delegation of care principles (see Section 5.3.4 Delegation of care), and any change in health status is reported immediately to the RN; and
- the RN (or an EN with an approved qualification in administration of medication) conducts a face-to-face visit and reviews the client on a weekly basis if assistance with the self-administration of Schedule 8 drugs is involved, see Section 8.1 7 day review.

If the client does not fall within these criteria, they must be classified under the Clinical Care schedule, see Section 7.3.1.3 Medication Administration – Clinical Care for more information.

PCWs can administer over-the-counter medication and apply prescribed or non-prescribed cortisone cream.

The CN provider must ensure that the assistance with self-administration of medication, and the administration of over-the-counter medications/creams, by an EN and/or PCW is planned, appropriately delegated, supervised and documented by an RN, see Section 5.3.4 Delegation of care.

The CN provider must also ensure that assistance with self-administration of medication meets the legislative requirements of the State or Territory where the services are delivered.
7.5 Other Items and Add-ons schedule
The Classification System includes an Other Items schedule which is comprised of add-on options for the provision of other CN services.

Most of these Other Items classifications can be added onto a Clinical or Personal Care core item number when a further combination of care or services are provided in the 28-day claim period.

The Other Items and Add-ons schedule classifications that can be claimed are:

- assessment (ongoing or no other services);
- palliative care phases (stable, unstable, deteriorating, terminal);
- bereavement follow-up (can only be claimed once);
- additional travel (see Attachment B Additional Travel);
- overnight care;
- second worker; and
- nursing consumables (see Attachment D Nursing Consumables).

NB: Palliative Stable is the only palliative care add-on item that can be claimed with a Personal Care Core schedule item where there is no requirement for an add-on from the Clinical Care schedule.

7.5.1 Assessment
This visit type is used to claim the initial comprehensive assessment undertaken by an RN of a client with ongoing or non-ongoing care needs, and at every 12 month anniversary (if there have been 13 consecutive 28-day claim periods) for clients with ongoing care needs.

If a client has been discharged from the CN program, and there is a break in services for more than one 28-day claim period, the Assessment item number can be claimed if the client is readmitted to the program. Where a client requires more than three assessment visits in a 12 month period, for example where the client is discharged from CN services and re-admitted on more than one occasion, prior approval will be required to claim a fourth (or more) assessment item.

For COVID-19 pandemic period specific measures related to this visit type, see Section 6 Assessment.

7.5.1.1 Assessment – ongoing community nursing services required
The Assessment classification for ongoing services can be claimed following the completion of a comprehensive assessment:

- once at the beginning of an episode of care; and
- after each 12 month period of ongoing care (13 consecutive claim periods).

This classification can be claimed in conjunction with:
• core and add-on item numbers from the Clinical Care and/or Personal Care schedules; or
• item numbers from the Exceptional Case schedule only when the Exceptional Case claim is at the beginning of the episode of care and not when a client moves from the Schedule of Fees into the Exceptional Case subcategory within an existing 12 month assessment.

The CN provider must communicate the outcomes from each comprehensive assessment to a client’s GP.

For COVID-19 pandemic period specific measures related to this visit type, see **Section 6 Assessment**.

7.5.1.2 Assessment only – no ongoing community nursing services required
An Assessment where no ongoing CN services are required can be claimed only once per client within three consecutive 28-day claim periods (84 days).

The CN provider must contact the client’s GP to provide information about the outcome of the comprehensive assessment, including any requests for referrals to allied or other health service/s, if these are required.

If the client requires a community support service, the CN provider must obtain the client’s consent and refer the client to the appropriate community support service for an assessment.

The only Other Item number that can be claimed in conjunction with this item is the Other Items – Additional Travel item number (if appropriate).

7.5.2 Palliative care
Palliative care add-ons are used for a client who has a diagnosis of a life-limiting illness and requires a palliative approach.

Palliative care focuses on the psychosocial aspects of the care for the client and their family and/or carers and reflects the resulting increase in care required.

Clinical aspects of palliative care, such as symptom control, will be claimed under a clinical care core visit type. If a client diagnosed with a life limiting illness requires only personal care services, this can be claimed under a personal care core visit type.

Examples of life-limiting illnesses include:
• metastatic cancers;
• local reoccurrence of cancer;
• end-stage organ failure, such as cardiac, renal or liver failure;
• end-stage dementia;
• acquired immunodeficiency syndrome; and
neurodegenerative disorders such as Huntington’s Disease or Motor Neurone Disease.

Palliative care services, including clinical interventions, should be coordinated and under the supervision of the specialist palliative care team, including the treating specialist, the client’s GP, and any other health providers involved in the client’s care.

Personnel used to deliver palliative care services include RNs or ENs, based on their qualifications and experience.

7.5.2.1 Palliative care phases
There are four Other Items - Palliative Care classifications which encompass the palliative care phases of:
- stable;
- unstable;
- deteriorating; and
- terminal.
For further details see Attachment C Palliative Care Phases.

7.5.2.2 Mix of palliative phases
It is possible that a client may move between two or more Palliative Care phases during a 28-day claim period.
Where this occurs, the CN provider should claim the Palliative Care phase that reflects the majority of care (based on number of visits provided or time spent) in that 28-day claim period.

7.5.2.3 Palliative care – claiming
Other Items – palliative care stable, unstable, deteriorating and terminal visit type item numbers can be claimed with the following:
- a Clinical Care schedule item number (excluding Post-Operative Eye Drops); and
- a Personal Care schedule item number (when there is an add-on from the opposing Clinical Care schedule).

The Other Items - palliative care stable, is the only palliative care item number that can be claimed with a Personal Care schedule item number (when there is no requirement for an add-on from the opposing Clinical Care schedule).

The Other Items - palliative care terminal item number:
- can only be claimed once for a client;
- can only be claimed after the death of a client; and
- cannot be claimed with any other Other Items - palliative care phase.

7.5.3 Bereavement follow-up
The Bereavement Follow-up add-on is used for visit/s to a bereaved family member or carer following the death of a client who recently received CN
services. The client must have been receiving CN services from the CN provider at the time of death.

The visit/s to the bereaved family member or carer should preferably not occur on the same day as the client’s death, but can be made within three months of the date of death.

The goal of care is to assess the bereaved family member or carer and, if required, refer them for further bereavement counselling and support.

Personnel used for a Bereavement Follow-up visit must be an RN or EN, based on their qualifications and experience.

7.5.3.1 Bereavement follow-up – claiming
Bereavement Follow-up can only be claimed once the client has died. The claim date for this item number must be the same start date as the final claim for payment regardless of when the bereavement visit/s actually occur.

7.5.4 Overnight nursing care
A CN provider may provide overnight nursing care for a client in a number of situations when overnight support is required.

Overnight care may be provided by an RN or EN where clinical care is required, or by a PCW where this is the appropriate level of care.

Overnight care is classified as active or inactive.

Active overnight care involves the provision of continuous active support throughout the night. The personnel (RN, EN or PCW) delivering care do not have a designated sleep time and provide assistance when required.

Inactive overnight care occurs where overnight support is needed, but the personnel delivering care can sleep when not required to provide care. During inactive overnight care, the personnel is available to provide assistance up to two times, for 30 minutes each time. If the personnel is up three or more times during the night, making a total of over one hour active duty per night, the entire shift can be claimed as an active overnight shift.

Overnight nursing care should be claimed in the same 28 day claim period as other required services provided to the client.

Overnight nursing care is not for the purpose of providing respite to replace or establish the role of a carer.

7.5.5 More than one worker assisting per visit (Second Worker)
There may be situations where a client requires more than one worker to assist the primary worker for some, or all, of the scheduled visits for CN services.
For example, over a 28-day claim period, a client has the following care profile:
- Core care requirement - Personal Care - Medium 56 visits.
  E.g. Non-weight bearing person - the personal care provided is comprised of
  the primary worker for 56 visits, who is assisted by a second worker for 28 of
  these visits for transfer and shower in the morning.

In these situations, a second worker add-on item may be claimed for the
delivery of services where the nursing care plan requires a second worker to
provide services to a client during the same visit for the same task.

To claim for the provision of second worker services, utilise the relevant
second worker add-on code from the Schedule of Fees.

7.6 Nursing Consumables
Nursing consumables items can be claimed by CN providers for
reimbursement for products used (excluding items contained the nurse’s
toolbox) during the provision of clinical care to a client in a 28-day claim
period.

Each of the nursing consumables item numbers available in the Schedule of
Fees have a set dollar amount attributed to them. The CN provider should
claim the Other Items - nursing consumables item number that is closest in
value to the actual cost (excluding items contained the nurse’s toolbox) within
the listed range for nursing consumables used in the provision of care to a
client during a 28-day claim period.

The CN provider must not include any nurse’s toolbox or GST component
when calculating which nursing consumable item number to claim. Payments
made to CN providers automatically add the GST component prior to
payment.

There is an upper reimbursement limit of $1,500 for nursing consumables per
client per 28 day claim period.

For further information, including the Schedule of Fees and claiming, see
Attachment D Nursing Consumables.
## Figure 7.1: Core Schedule and potential add-ons

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Core Item</th>
<th>Opposing Schedule add-on</th>
<th>Potential Other Items Schedule add-ons if required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Care</strong></td>
<td>CORE Personal Care item number</td>
<td>ADD-ON from Opposing Schedule for Clinical Care</td>
<td>Assessment (NA02)</td>
</tr>
<tr>
<td><strong>Clinical Care</strong></td>
<td>CORE Clinical Care item number</td>
<td>ADD-ON from Opposing Schedule for Personal Care</td>
<td>Assessment (NA02)</td>
</tr>
<tr>
<td><strong>EC Status</strong></td>
<td>Assessed EC item number</td>
<td>N/A</td>
<td>Assessment (NA02 – only first 28-day claim period)</td>
</tr>
<tr>
<td>Intervention</td>
<td>Clinical nursing activities</td>
<td>Clinical Support activities</td>
<td>Personal care activities</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Hygiene</td>
<td></td>
<td></td>
<td>Shower/sponge/bath</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dress/groom/personal hygiene</td>
</tr>
<tr>
<td>Mobility</td>
<td></td>
<td></td>
<td>Transferring</td>
</tr>
<tr>
<td>Output</td>
<td>Lymphoedema (if undertaken by an RN with a qualification from a recognised lymphoedema course)</td>
<td></td>
<td>Observation and/or assistance with toileting and/or showering</td>
</tr>
<tr>
<td></td>
<td>Bowel management</td>
<td></td>
<td>Specimen collection-non venipuncture</td>
</tr>
<tr>
<td></td>
<td>Enema ordered by GP/Specialist</td>
<td></td>
<td>Changing, emptying urinary catheter bags</td>
</tr>
<tr>
<td></td>
<td>Bladder care</td>
<td></td>
<td>Cleaning catheter site</td>
</tr>
<tr>
<td></td>
<td>Suppository/microenemas</td>
<td></td>
<td>Assistance with application of stoma appliance where the client maintains responsibility for care</td>
</tr>
<tr>
<td></td>
<td>Urinary catheter insertion</td>
<td></td>
<td>Perineal care</td>
</tr>
<tr>
<td></td>
<td>Urinary stoma care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flip flow valve change</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nephrostomy care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stoma therapist visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stoma assistance where client unable to maintain responsibility for care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Input</td>
<td>Gastrostomy care</td>
<td></td>
<td>Assistance with eating, if required to meet nutritional needs</td>
</tr>
<tr>
<td></td>
<td>Naso gastric/lavage feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parenteral feeding/PEG feeds</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Central/peripheral venous device management/IV therapy &amp; line management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aids/ Appliances</td>
<td></td>
<td></td>
<td>Fitting aids &amp; appliances e.g. splints, callipers, compression garments/stockings</td>
</tr>
<tr>
<td>Respiratory Care</td>
<td>Tracheostomy care</td>
<td></td>
<td>Assist with self-care administration of oxygen</td>
</tr>
<tr>
<td></td>
<td>Oxygen/inhalation therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Common Community Nursing Activities by Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Clinical nursing activities</th>
<th>Clinical Support activities</th>
<th>Personal care activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Coordination</strong></td>
<td>Care coordination</td>
<td>Reporting – delegation by RN/EN</td>
<td></td>
</tr>
<tr>
<td><strong>Wound Management</strong></td>
<td>Simple/Complex wound dressing</td>
<td></td>
<td>Basic first aid treatment</td>
</tr>
<tr>
<td></td>
<td>Pressure area care/prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ulcer care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wound assessments and clinical interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Removal of sutures</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Central/peripheral venous device management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compression bandaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment &amp; Monitoring</strong></td>
<td>Comprehensive needs assessment</td>
<td></td>
<td>Maintenance of skin integrity</td>
</tr>
<tr>
<td></td>
<td>Assess/supply equipment needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning(review</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor/surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carer support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health education/teaching</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vital signs/observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td>Insulin injection</td>
<td>Short term assistance with self-management of vital signs/Blood glucose (BGL)</td>
<td>Prompting self-management of medication from a DAA (Dose Administration Aid)</td>
</tr>
<tr>
<td></td>
<td>Administration of optical/oral/rectal/ vaginal/aural/ IMI/ IV/ SC medication</td>
<td>Management/Education for self-administration of medications</td>
<td>Non-prescribed eye drops/ointment</td>
</tr>
<tr>
<td></td>
<td>Syringe driver/pump management</td>
<td></td>
<td>Eye toilet</td>
</tr>
<tr>
<td></td>
<td>Application of prescribed topical medication (other than cortisone cream)</td>
<td></td>
<td>Assist self-administration of medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Application of non-prescribed skin cream or lotion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Application of cortisone cream (either prescribed or non-prescribed)</td>
</tr>
</tbody>
</table>
8 Review of care
The CN provider must conduct a review of the care needs of a client, as a minimum, at specified times throughout the client's episode of care depending on the type of care they receive. Each review must be recorded in the client's documentation, even where the care continues unchanged, and include the reviewer's name, signature, designation and date.

This should include a review of the person's capacity / level of independence, as documented in the GP referral and/or initial comprehensive assessment undertaken by the RN.

8.1 Seven day review
A client classified in the Personal Care schedule who requires assistance with self-administered medication of Schedule 8 drugs from a Dose Administration Aid, must be reviewed by an RN (or an EN with an approved qualification in administration of medicines) every seven days.

All clients with Exceptional Case status must be seen by an RN at least once per week.

8.2 28 day review
The CN provider will review the care provided to the client at the end of the 28-day claim period.

The purpose of this review is to review the nursing care plan and existing documentation to verify that the classifications and care delivered reflect the item number/s claimed, including the:

- core schedule visit type classification;
- opposing schedule visit type add-on (if required); and
- other care and service/s provided from the Other Items schedule (if required).

*Changes to 28 Day Reviews for the duration of the COVID-19 Pandemic – the following change was notified to CN Providers on 20 March 2020 via CN Bulletin No. 19 and is therefore effective from that date until 31 December 2021*

For the duration of the COVID-19 pandemic, CN providers may conduct the 28 day review by telephone, where clinically appropriate, to alleviate the need for an RN or EN to travel to a client's house where the sole purpose of the visit is to conduct this review. The client's progress notes / file should be updated following the review.

8.2.1 Personnel undertaking review
If the client is classified under the Clinical Care schedule (either as a core or add-on), the review at the end of each 28-day claim period must be conducted by an RN.
The review at the end of each 28-day claim period of clients receiving CN services under the Personal Care schedule (with no Clinical Care add-on) must be conducted by either an RN or an EN.

8.3 Three monthly review
The three monthly review must be conducted prior to the end of every third 28-day claim period by an RN, regardless of the type of CN services being delivered. A file note must be placed on the client’s care documentation when the review is completed. All delegated care details must be appropriately documented in clinical records and kept on the client’s file.

In undertaking the review, the RN will identify any changes required to the CN services, and document and implement those changes in consultation with the client.

If the review identifies a change to services is required, the CN provider must either:
- reclassify the client within the Classification System; or
- identify the need for the client to be assessed through the Exceptional Case process; or
- discharge the client from CN services.

For a client classified as palliative care stable phase, the RN will identify whether claiming the palliative care stable add-on continues to be appropriate.

If the change to care needs results in a reduction in personal care services to 1.5 hours or less per week, and there is no clinical need for CN services, the CN provider should consider discharging the client and referring them to VHC for an assessment for personal care services, see Section 6.2 Personal Care Assessment.

8.4 Review of care summary

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Activities</th>
<th>Personnel Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seven days for Personal Care with Schedule 8 drug assistance</td>
<td>Review medication management and ensure the delegations are still appropriate. A clinical care add-on may be claimed for this review.</td>
<td>RN; or EN with an approved qualification in administration of medication.</td>
</tr>
<tr>
<td>Seven days for clients with Exceptional Case (EC) status</td>
<td>Review all clinical and personal care needs There is no clinical care add-on that can be claimed. The review is included in the EC funding.</td>
<td>RN</td>
</tr>
<tr>
<td>28-day claim period</td>
<td>Includes a review of the nursing care plan and existing documentation to verify that the classifications and care delivered reflect the item number/s claimed.</td>
<td>RN; or EN if only personal care is being delivered</td>
</tr>
</tbody>
</table>
Every three months | Includes but not limited to:  
- identification of any changed care needs;  
- review of nursing care plan and all documentation relevant to care needs;  
- update of nursing care plan where necessary;  
- consultation with the client about nursing care plan updates;  
- any relevant assessment tools;  
- verification the classifications and care delivered reflect the item number/s claimed. | RN  

At any time if care needs change | Review and update all assessment documentation and the nursing care plan relevant to the changed care needs. | RN

**Note**: It is expected that, wherever possible, the review occurs in the same visit as a visit for the provision of clinical/personal care.

### 8.5 Communication with the client’s GP

DVA considers the client’s GP to have ongoing clinical oversight and management of the client’s care. As such, the CN provider must communicate with a client’s GP on a regular basis, and record the communication on the client’s care documentation. This should occur:

- on admission following a comprehensive assessment of care needs;
- following a review when the assessed care needs change;
- every 12 months following a comprehensive assessment of care needs; and
- on discharge from CN services. When a client is discharged from CN services, a summary of the care provided during the episode of care, reason for discharge, and any additional services the client may require should be documented.

The CN provider must identify:

- any significant change to clinical and/or personal care needs; and
- the need for an allied or other community health service and request a referral for this service/s.
9 Discharge from Community Nursing services
A client must be discharged by a CN provider if the client:
• is absent from CN services for more than 28 days;
• has been permanently admitted to an aged care facility;
• transfers from the existing provider to another CN provider (with DVA’s approval if required);
• moves permanently to another location; or
• no longer requires CN services.

The date of discharge from CN services is the date of the last face-to-face visit. The client’s episode of care ends on the date of discharge.

A client’s discharge should be notified to the client’s GP verbally and in writing, including if a client self-discharges, and any recommendation for other services a client may require.

A discharge should not occur if the client is:
• absent from CN services for 28 days or less, for any purpose, e.g. for residential respite care, hospitalisation, holiday;
• absent for short periods which does not interrupt planned CN services; or
• visited regularly, but infrequently, over a period longer than 28 days and which is considered one continuous delivery of CN services (e.g. 6 – 8 weekly indwelling or supra pubic catheter change).

9.1 Absences for 28 days or less
Absences from CN services may be due to admission to an acute facility or hospice, a period of rehabilitation, residential respite, or going on a holiday.

If a client is absent from CN services for 28 days or less, and still requires CN services, they should recommence their CN services with the same CN provider within the 28-day claim period. This ensures continuity of care.

If the care needs have changed, the CN provider must update all assessment documentation and the nursing care plan. Item numbers must also be reviewed to ensure they reflect the type of care being provided.

Outcomes of the assessment must be reported back to the client’s GP.

9.2 Readmission after discharge
If CN services are required again after being discharged, regardless of the period of time since discharge, the CN provider must:
• obtain a new referral prior to admission back into the CN program; and
• conduct a new comprehensive assessment and develop a new nursing care plan.
10 Policies and care documentation

10.1 Clinical and administrative policies

A CN provider must have written clinical and administrative policies and procedures in place which adhere to the provisions contained in the relevant State or Territory legislation and which are appropriate for a CN setting.

At a minimum, these policies must include:
- work health and safety;
- incident, accident and dangerous occurrence management;
- infection control;
- medication management including adverse event procedures;
- care documentation;
- client not responding; and
- delegation of care.

All policies must be reviewed regularly (at a minimum of every three years or in line with relevant legislation), to take into account industry changes to clinical practices. Policies and procedures should reflect current legislation and regulatory requirements, standards and contractual agreements. DVA looks to the Australian Commission on Safety and Quality in Health Care (ACSQHC) for guidance in relation to standards for the provision of health care services including community nursing.

10.2 Care documentation

A CN provider must develop and maintain an appropriate care documentation framework for a CN setting, based on the principles of the CN industry recognised evidence based best practice.

A client’s care documentation must be developed in conjunction with the client and, if applicable, the carer and family. The client must be provided with, or be able to access in a timely manner, an up-to-date copy of the care documentation. The client, and if applicable the carer and family, must sign the nursing care plan. The care documentation must be updated regularly at assessment and review, as changes occur and when additional information becomes available. All services must be delivered in accordance with the nursing care plan.

As a minimum, care documentation must include a nursing care plan that must be developed and completed by an RN. A nursing care plan must include the:
- clinical and Personal Care activities identified from the assessment;
- goal/s of care (short and long term);
- nursing intervention/s;
- desired outcome/s;
- delegation of care;
- review dates; and
- agreed days and approximate timeframes that services will be delivered.
10.3 Privacy, documentation and record keeping

All CN providers must develop, maintain and store appropriate documentation relating to the claiming, administrative, and clinical aspects of the client’s episode of care. This includes having the following clearly identified and documented:

- valid referrals; and
- assessments; and
- nursing care plans; and
- clinical nursing notes; and
- dated reviews of care and the outcomes; and
- related care documentation; and
- claiming history.

CN providers must ensure the storage and security of personal information regarding a client is in accordance with the Australian Privacy Principles that can be accessed through the Office of the Australian Information Commissioner’s at: [www.oaic.gov.au/privacy-law/](http://www.oaic.gov.au/privacy-law/).

The Office of the Australian Information Commissioner’s Guide to Information Security provides guidance on information security, specifically the reasonable steps entities are required to take under the Privacy Act 1988 (Privacy Act) to protect the personal information they hold. CN providers must not perform an act, or engage in a practice under the agreement or a subcontract, that would breach an Australian Privacy Principle under the Privacy Act. [www.oaic.gov.au/agencies-and-organisations-guides/guide-to-securing-personal-information](http://www.oaic.gov.au/agencies-and-organisations-guides/guide-to-securing-personal-information).

The CN provider must retain any documents relating to the care of a client, or documentation relating to payments claimed for the client, in accordance with legislation regarding the retention of medical records in their State or Territory.

Where records include personal information about clients (such as name, address, age and services received) their confidentiality must be protected. CN providers must ensure that records are stored securely and only accessible by personnel that have undergone appropriate security checks, and will access only information that is required for the personnel to perform their duties.

10.4 DVA’s right to access records and premises

The CN provider must make the care, administrative and/or claiming documentation (copies or electronic) available to DVA, or any person or organisation approved by an authorised DVA delegate, and provide reasonable access to the documentation upon request. This information will be made available by a CN provider on request from DVA. DVA will ensure that reasonable timeframes are allowed for the supply of care, administrative and/or claiming information.

As a component of the CN program’s Quality Framework (QF) or Performance Monitoring processes, DVA may request copies of the care,
administrative, and/or claiming documentation to be sent to DVA to enable these processes to occur. DVA will retain copies of this documentation where required.

10.5 Refusal of services
A client has the right to refuse either some or all of the proposed CN services. A legally authorised representative under State or Territory law (e.g. The Public Trustee, Guardian, a holder of an appropriate Special Power of Attorney, etc.) can also refuse some or all of the proposed CN services on behalf of the client.

If CN services are refused, the CN provider must:
- inform the client of the expected consequences of refusal;
- notify the client’s GP of the refusal; and
- document the refusal and the actions undertaken as a result of the refusal.

A client’s refusal of CN services on a previous occasion does not exclude the client from accessing CN services in the future.

10.6 Client not responding
The CN provider should develop, together with the client, an individual plan of action to be implemented as part of their policies and procedures in the event that a client does not respond when the care worker arrives to deliver a scheduled service visit.

Where a client does not want an individual plan of action, providers are required to have a generic plan in place to ensure the safety of all clients without an individual plan.

For any occasions where the client not responding plan has been implemented/activated, a summary of events should be documented in the client’s care documentation.

CN providers should have processes in place to minimise situations where a client forgets about a service visit (e.g. contacting the client or carer to remind them of the upcoming service visit). Where the CN provider has not activated an individual or generic client not responding plan to check the client’s safety, the CN provider must not claim a visit. For further information about claiming for visits in this situation, see Section 11.6 Cancelled Visits.

10.7 Rights of carers and health care recipients
‘Carers’ refers to family or regular unpaid carers providing the majority of support for a client. A carer may or may not live with the client.

The Carer Recognition Act 2010 aims to increase recognition and awareness of carers and to acknowledge the valuable contribution they make to society. The Carer Recognition Act 2010 provides a Statement for Australia’s Carers
that outlines principles and obligations for Australian Government agencies and organisations that they contract.

As a contracted organisation, a CN provider should take all practicable measures to ensure that its officers, employees and agents:

- have an awareness and understanding of the Statement for Australia’s Carers; and
- take action to reflect the principles of the Statement in developing, implementing, providing or evaluating care supports.


In addition, the Australian Charter of Healthcare Rights lists rights and responsibilities for everyone receiving health care in Australia.
11 Claiming

A CN provider claims for payment for the delivery of CN services to a client through Services Australia (Medicare). All claims for payment must be submitted to Medicare within six months of service delivery for payment.

DVA recommends Medicare’s online claiming services as they provide a number of efficiencies and cost-savings for health care providers. The CN program intends to move towards online claiming as the only method for CN providers to claim for services.

DVA will accept financial responsibility for the provision of CN services to meet the clinically assessed needs of clients. The CN services must be delivered in accordance with the Notes and the Terms and Conditions.

A client must never be asked to provide additional payment for the delivery of CN services by a CN provider.

11.1 28-day claim period

DVA pays CN providers retrospectively for the delivery of all required CN services to a client in a 28-day claim period.

11.1.1 Changes in care needs during the 28-day claim period

If a client’s care needs change during a 28-day claim period, the CN provider must reassess the classification/s:

- according to the core CN service provided (based on the majority of care principle);
- if required, utilising an add-on from the opposing schedule (based either on lesser visit count or lesser time, whichever is applicable; and/or
- if required, adding any add-ons from the Other Items schedule (based on additional services or nursing consumables provided).

If the care needs of a client receiving services under the Exceptional Case process change during a 28-day claim period, the CN provider must undertake the Exceptional Case status variation or interruption to care process as outlined in Attachment A Exceptional Case process.

11.1.2 Two providers in a 28-day claim period

Where a client requires services from two CN providers in a 28-day claim period, services may be claimed directly through Medicare by both providers.

Where a client receives services from two providers, there must be no duplication of services delivered by the providers. It would be expected the providers would liaise with each other to ensure there is no duplication, and that the client’s full clinical needs are met.

Where one provider is delivering clinical care and one is delivering personal care, prior approval is required from DVA to claim opposing core schedule items. Where there are two providers delivering the same core service but at
different times, e.g. on different days or one in the morning and one in the afternoon, the same core care type would be claimed by both providers, based on number and length of visits by each provider.

Situations where the client may require services from two providers include when a client:
- is referred to another CN provider (e.g. post hospital admission); or
- when one provider is not able to provide all the required care, and two providers are required to fully meet a client’s clinical care needs.

However, some services can only be claimed once in a 28 day claim period per client. These are:
- Assessment only – no other services required;
- Exceptional case status; and
- Coordinated Veterans Care (CVC) Program items.

11.2 Minimum Data Set and multiple item numbers
The Minimum Data Set (MDS) is required for most item numbers in the:
- clinical care schedule;
- personal care schedule; and
- Other Items schedule.

However the following items do not require MDS:
- additional travel;
- nursing consumables; and
- CVC – UP05 and UP06.
For more information, see Attachment F Submitting Minimum Data Set.

11.3 Goods and Services Tax (GST)
The fees in the Schedule of Fees and for Exceptional Case status are exclusive of GST, GST will be added (where appropriate) when the claim for payment is processed by Medicare, regardless of the claiming method used. Medicare will produce a GST compliant Recipient Created Tax Invoice (RCTI) on behalf of DVA at the time of payment.

11.4 Timeframe for claiming
A claim for payment for CN services, regardless of the claiming method used, must be forwarded to Medicare for processing within six months of the first day of the 28-day claim period.

11.5 Submitting a claim for payment
A CN provider must ensure that the details on their claim for payment are correct prior to submitting to Medicare.

In submitting a claim for payment for CN services provided to a client, the CN provider certifies that the services:
- were delivered by the CN provider or a subcontractor;
- were provided under an agreed nursing care plan for the client; and
- the claim is a true representation of the CN services actually provided.
11.6 Cancelled visits
Where a visit is cancelled at short notice or the nurse / PCW arrives for a visit and the client is not home, the visit that would otherwise have been made can be claimed. Less than 24 hours’ notice of cancellation of a visit is considered short notice. This includes when an individual or generic client not responding plan has been actioned, and the outcome documented in the client’s care documentation.

11.7 Retention of claims
CN providers must retain their claims in a storage system which is able to be accessed for review purposes.

A CN provider must be compliant with the Australian Privacy Principles, see Section 10.3 Privacy, documentation and record keeping.

11.8 Payment method
CN providers are paid directly into a nominated bank account. For a CN provider to be paid directly into a nominated bank account, these details should be provided to Medicare on 1800 700 199. For information on this payment method, or to access online claiming information and forms visit: https://www.servicesaustralia.gov.au/organisations/health-professionals/forms/hw052

11.9 Queries about claims
If a CN provider has any queries about the status of a claim/s for payment please contact Medicare on 1300 550 017 (option 2).

11.10 Unsuccessful claim/s for payment
A claim for payment may be unsuccessful in full or in part. Medicare will inform the CN provider if a claim for payment has been unsuccessful and the reason/s why. Depending on the reason/s the claim for payment has been unsuccessful, Medicare may return either part or all of the claim documentation to the CN provider.

11.11 Resubmitting a claim/s for payment
If appropriate, a claim for payment or a component of a claim for payment should be corrected and resubmitted to Medicare. If only part of the claim for payment has been unsuccessful, it can be corrected and included with the next claim for payment made to Medicare.

11.12 Adjustments to a claim/s for payment
An adjustment may need to be made to a claim/s for payment and may occur for one of the following reasons:
- after a claim has been submitted, if an incorrect payment has been made; or
- prior to a claim being submitted, if changes have occurred to the CN services delivered to a client with Exceptional Case status. For further details, see Attachment A Exceptional Cases - Variation.
11.13 Incorrect payment/s
An incorrect payment may involve either an overpayment or an underpayment. An incorrect payment may be identified by DVA or the CN provider. If an incorrect payment is identified by DVA, Medicare will contact the CN provider and manage the adjustment process.

If a CN provider identifies an incorrect payment, it must request an adjustment from Medicare. The request must be in writing and include the following information:

- the reason for the adjustment;
- the provider number;
- the claim number/s; and
- the details of the client/s involved.

All requests for adjustments should be sent to Medicare, using Services Australia’s Voluntary acknowledgement of incorrect payments (MO057) form.

When an adjustment is made, a GST-compliant Recipient Created Adjustment Notice (RCAN) is provided to the CN provider. The RCAN replaces the RCTI previously provided with the incorrect payment.

11.14 Inappropriate claiming
DVA has systems in place to monitor and report on the servicing and claiming patterns of services provided under the CN program. These systems are aimed at detecting and preventing fraud and non-compliance.

Over-servicing is defined as providing a client with health care services that, when viewed objectively, are not required for the person’s health and wellbeing. This includes services that, despite being provided at normal levels, is provided without a clear clinical or personal care need.

Under-servicing is defined as providing a client with a lower level of health care services than is clinically required to meet the clinical or personal care health care needs. It is a part of the goals of DVA and the CN program to provide clients with quality and appropriate health care services.

The Resource Management Guide No. 201 Preventing, detecting and dealing with fraud (2017) defines fraud against the Commonwealth as “dishonestly obtaining a benefit, or causing a loss, by deception or other means”.

Fraud against the Commonwealth may include (but is not limited to):

- theft;
- accounting fraud (false invoices, misappropriation etc.);
- unlawful use of, or obtaining property, equipment, material or services;
- causing a loss, or avoiding and/or creating a liability;
- providing false or misleading information to the Commonwealth, or failing to provide it when there is an obligation to do so;
- misuse of Commonwealth assets, equipment or facilities;
- cartel conduct;
• making or using false, forged or falsified documents;
• wrongfully using Commonwealth information or intellectual property;
and
• any offences of a like nature to those listed above.

DVA has an obligation to meet Fraud Control arrangements under the Public Governance, Performance and Accountability Act 2013, failure to meet the obligations to conduct business with the Commonwealth in an honest manner may result in provider education, recovery of monies or prosecution.

11.15 Recovery of overpayments
DVA will recover any overpayments identified during regular contract management performance monitoring processes and take appropriate action as required. Action may include:
• offsetting any overpayment against future payments; and/or
• recovering, as a debt due to the Commonwealth, any money owing to DVA (plus reasonable interest) in a court of competent jurisdiction.
12 Continuous improvement, innovation and quality and safety audits

12.1 Continuous improvement and innovation
CN providers must work within a framework of continuous improvement and innovation to deliver industry recognised evidence based best practice CN services.

CN providers must have a continuous improvement framework in place. A continuous improvement framework is made up of quality systems and at a minimum, includes systems for:

- the management of risk, including health and safety risks to a client; and
- the management of feedback to other health professionals; and
- the management of complaints and feedback from clients and other individuals; and
- the evaluation of continuous improvement outcomes; and
- the management of records to ensure maintenance and appropriate access.

12.2 Performance monitoring
All CN providers are subject to performance monitoring processes. The aim of performance monitoring is to measure compliance with contractual requirements, including both administrative and clinical requirements, and determine the quality of CN services being delivered.

Performance monitoring utilises claiming data to validate assessment and classification within the Schedule of Fees.

The key objectives are to:

- ensure compliance with the Notes;
- monitor the appropriateness and quality of CN care being provided to clients; and
- minimise the risk of errors or fraud.

12.3 Quality and safety audits
In accordance with the Terms and Conditions for the Provision of Community Nursing Services, audits may be conducted to assess the quality and safety of nursing services delivered by CN providers.

The purpose of quality and safety audits is to review compliance with DVA requirements as outlined in the Notes and the Terms and Conditions, and to ensure the provider continues to deliver high quality, safe and person-centred CN services to DVA clients.

Assessment may include a desktop review or onsite visits. The mix of activities undertaken by DVA to monitor CN providers’ performance, and the frequency with which these activities are undertaken, will be based on a CN provider’s business structure, business processes, service delivery claiming patterns, data analysis, random selection, and any issues which may arise over time.
12.4 Recognition of accreditation
In determining the mix and frequency of performance monitoring activities, DVA will recognise a CN provider’s achievement of specific types of accreditation through recognised Australian accreditation agencies for health care services.

This recognition is based on the similarities between the compliance measures of these specific accreditation processes and DVA’s Performance Monitoring process. The achievement of accreditation does not replace DVA’s Performance Monitoring process.

Some quality and accreditation frameworks (healthcare focused) recognised by DVA include, but are not limited to:

- Quality Improvement Council (QIC) Health and Community Services Standards [QIC Standards | QIP accreditation](http://example.com)

Other quality and accreditation frameworks (not healthcare focused) include, but are not limited to:

- ISO 9001 Quality Management Systems (international standard)
- National Disability Insurance Scheme (NDIS) Practice Standards

Accreditation organisations recognised by DVA are reviewed over time, as required.
13 Interaction with other health and community support service providers

13.1 Veterans’ Home Care (VHC) Program
A CN provider can deliver CN services to a client receiving domestic assistance, home and garden maintenance, or respite services under the VHC Program. All referrals for VHC services must be made to a VHC Assessment Agency. The contact number for VHC Assessment Agencies is 1300 550 450. Further information about the VHC Program can be found on the DVA website at Veterans’ Home Care.

When a client is assessed as requiring low level personal care services (up to and including 1.5 hours of personal care services per week) and the client does not have a clinical need for CN services, the personal care services should be provided through VHC.

A client must not receive ongoing personal care services under VHC while they are also receiving CN services for a clinical and/or personal care need. All of the required personal care services must be delivered as a part of the CN services, see Section 6.2 Personal care assessment.

13.1.1 Short term clinical intervention
When a client receiving personal care services under VHC requires a short term clinical intervention, an exemption may be approved by DVA to allow the personal care to continue through VHC at the same time as the clinical intervention is provided through the CN program. Contact DVA to request an exemption, see Section 1.4 Contacting DVA for contact details.

An exemption may be considered in the following circumstances:
- where a client has received long term personal care services through VHC and requires some level of CN services through the CN program but the prospect of receiving these personal care services from a different provider through the CN program causes a high level of stress and anxiety; or
- where the client is located in an area where the only CN provider is unable to deliver the required level of personal care services and the provision of personal care services through VHC is the only option for the client.

Requests for an exemption will be assessed on a case-by-case basis, depending on the circumstances. An agreement for a limited number of 28-day claim periods may be given.

The overlap of services in these circumstances may only occur if the provision of personal care services is not duplicated under both programs and the health and safety of the client is not put at risk.

Where an exemption is granted, the CN provider must ensure they regularly communicate with the relevant VHC service provider to ensure that the
personal care services do not impact on the treatment outcomes of the CN services.

There are also circumstances where a client has previously received high level personal care services under the CN program and then requires a low level of personal care services. Where a CN provider seeks an exemption, DVA will give consideration to the client’s care needs, situation and past history to determine whether the VHC or CN program provides the personal care services.

13.2 Rehabilitation Appliances Program (RAP)
A range of aids and equipment can be obtained through the Rehabilitation Appliances Program (RAP). This includes supplies and aids for continence, stoma care, palliative care and diabetes care, which can be obtained through the National Schedule of RAP Equipment (RAP Schedule). The RAP Schedule and referral details can be accessed on the DVA website at Rehabilitation Appliances Program.

13.3 Credentialed diabetes educators
A client may access diabetes education services from a credentialed diabetes educator, where this service cannot be delivered by the CN provider. This scenario would typically arise when a CN provider does not have any credentialed diabetes educators as part of their personnel.

Where a CN provider does have credentialed diabetes educators as part of their personnel, a credentialed diabetes educator not employed by the CN provider must not claim payment for diabetes education services provided to a client who is receiving CN services, as the cost of diabetes education services is included in the fee paid to CN providers.

13.4 Open Arms – Veterans and Families Counselling
Open Arms provides free and confidential, nation-wide counselling and support for a range of mental health conditions, such as post-traumatic stress disorder (PTSD), anxiety, depression, sleep disturbance and anger for current and ex-serving (veteran) defence force personnel and their families. Support is also available for relationship and family matters that can arise due to the unique nature of military service.

Open Arms counsellors have an understanding of military culture and can work with clients to find effective solutions for improved mental health and wellbeing.

Open Arms provides the following services:
- individual, couple and family counselling and support for those with more complex needs;
- services to enhance family functioning and parenting;
- after-hours crisis telephone counselling;
- group programs to develop skills and enhance support;
- information, education and self-help resources; and
• referrals to other services or specialist treatment programs.

Veterans and their families can seek assistance from Open Arms by calling 1800 011 046. More information can be found on the Open Arms website: https://www.openarms.gov.au/.

13.5 Home Care Packages Program
The DOH’s Home Care Packages (HCP) Program provides four levels of home care options covering basic home care through to complex home care. The four levels of home care provide a continuum of care options:
• HCP Level 1 - Basic care;
• HCP Level 2 - Low level care;
• HCP Level 3 - Intermediate level care; and
• HCP Level 4 - High level care.

All package levels will have access to nursing and allied health services, if a need for these services is identified.

In addition, approved providers who provide Home Care Packages at any level will also be able to receive a ‘Veterans’ Supplement in Home Care’ or ‘Dementia and Cognition Supplement’ if the care recipient meets certain eligibility requirements.

A ‘Veterans’ Supplement in Home Care’ is available for clients with an accepted service-related mental health condition. This supplement will be automatically paid after consent to disclose their eligibility for the ‘Veterans’ Supplement in Home Care’ is received from the client.

While clients may be eligible for both the ‘Veterans’ Supplement in Home Care’ and the ‘Dementia and Cognition Supplement’, the approved provider may claim only one supplement for a client. Further information on providing aged care services is available on the DOH website at Providing aged care services | Australian Government Department of Health.

To receive a HCP, a client, as any other member of the community, must have an assessment by an Aged Care Assessment Team (ACAT) assessor.

Clients have the same right of access to HCPs, and other forms of packaged care, as any other member of the community. Specifically, clients should not be discriminated against when accessing services through a Home Care Package on an assumption that DVA will provide for all their care needs.

A HCP recipient, including a DVA client, may be asked to pay a fee for their home care services. DVA will pay this fee for clients who are former Prisoners of War or Victoria Cross recipients.

All HCPs are delivered on a Consumer Directed Care (CDC) basis. CDC packages give older people greater say and control over the design and delivery of community services provided to them and their carers.
Under CDC, clients will determine the level of involvement they would like to have in managing their own package. They will be provided with a personalised budget so that they can see how much funding is available for services and how the money is being spent. **Note:** It is not proposed that CDC will be a component of the CN program or other DVA home care programs at this time.

For further information about CDC, visit [www.myagedcare.gov.au](http://www.myagedcare.gov.au).

DVA and DOH have a no duplication policy in place. Eligible persons are able to access both DVA and DOH aged care and community support services, as long as there is no duplication in the services being delivered. For example, if a DVA client is in receipt of personal care through CN, they are unable to also receive personal care through a HCP. Where a client is in receipt of both DVA funded CN and a HCP, the providers delivering the two programs must liaise to coordinate the care being delivered.

13.5.1 Home Care Level 1 and Level 2 packages
The Home Care Level 1 and Home Care Level 2 packages (equivalent to low level residential care) are not intended to provide comprehensive clinical services, but some nursing services may be provided.

13.5.2 Clinical nursing services
A CN provider may deliver CN services to a client on a Home Care Level 1 or 2 package where there is assessed clinical need. Where a client is in receipt of a Home Care Level 1 or 2 package, the HCP provider and CN provider must ensure there is no duplication of CN services delivered to meet an assessed clinical need.

13.5.3 Personal care services
A CN provider should not deliver CN services to a client on a Home Care Level 1 or 2 package who requires personal care services only. All of the personal care services should, where possible, be provided under the HCP.

13.5.4 Clinical nursing and personal care services
Where a client on a HCP requires one-off, temporary, infrequent or irregular CN services (e.g. short term wound care or a catheter change), these clinical nursing interventions can be provided through the CN program. However, all of the personal care services should, where possible, be provided under the HCP.

Where a client with an assessed clinical need for regular ongoing CN services also requires personal care services, the CN provider should liaise with the provider of the HCP to determine which service will provide all the personal care services.
Note: There must not be a duplication in the delivery of any clinical or personal care services, nor should the clinical or personal care services be shared between a HCP provider and a CN provider.

13.5.5 Cessation of clinical nursing services
When a client on a HCP no longer requires regular ongoing clinical nursing services, all of the personal care services should, where possible, be provided through the HCP. In such situations, the CN provider may need to liaise with the HCP provider to ensure a smooth transition of personal care services from the CN program to the HCP. The CN provider must not cease providing personal care services to the client until the arrangements with the HCP provider are in place.

There may be situations where a HCP provider is unable to deliver personal care services to a client with no assessed need for clinical nursing services. In such situations, the CN provider must continue to provide the personal care services until the HCP provider is in a position to do so.

The CN provider should also liaise with the HCP provider to ensure that the personal care services are put in place in a timely manner, noting that clients have the same right of access to HCP services as other members of the community, and that clients should not be discriminated against for HCP services on an assumption that DVA will provide for all their care needs.

13.5.6 Home Care Level 3 and Level 4 packages
The Home Care Level 3 and Level 4 packages (equivalent to higher level residential care) should provide for all assessed clinical and/or personal care needs.

However, if the HCP cannot meet all of a client’s care needs, a DVA client can continue to access DVA services when in receipt of a Home Care Level 3 or 4 package, as long as there is no duplication in the services being delivered. If this is the case, the CN provider must work with the HCP provider to ensure there is no duplication of CN services.

13.5.7 Commonwealth Home Support programme
The Commonwealth Home Support programme (CHSP) aims to help older people stay independent and in their homes and communities for longer. The CHSP works with clients to maintain independence, and is an entry-level support service.

Information can be accessed online at: www.myagedcare.gov.au/help-home/commonwealth-home-support-programme.

Under the no duplication of care policy, eligible persons are able to access services through both DVA funded CN and the DOH funded CHSP, providing there is no duplication in the services being delivered. Where a client is in receipt of both DVA funded CN and a CHSP, the providers delivering the two programs must liaise to coordinate the care being delivered.
13.5.8 Transition Care Programme
A CN provider cannot deliver CN services to a client who is receiving Transition Care.

Transition Care provides goal oriented, time limited and therapy focused care to help older people at the conclusion of a hospital stay and is for older people who may otherwise be eligible for residential aged care.

To enter Transition Care, clients may require an assessment by an Aged Care Assessment Team (ACAT) assessor while they are still an in-patient of a hospital. This can be organised through the hospital where the client has received their acute/sub-acute care. A client can only enter transition care directly upon discharge from hospital

More information on Transition Care can be found at the following link: www.myagedcare.gov.au/after-hospital-care-transition-care.

See Section 3.2 referrals from hospitals and nurse practitioners for information relating to referrals to CN following a hospital stay.

13.5.9 Short-Term Restorative Care Programme
The Short-Term Restorative Care (STRC) Programme is a form of flexible care administered by DoH. It has been established to increase the care options available to older people and improve their capacity to stay independent and living in their homes.

The CN provider should work with the STRC provider to ensure that all care needs required are provided to the client and that there is no duplication between the services. Any existing nursing care plans should be coordinated between the STRC and CN provider so that the most appropriate services are provided according to the client’s individual needs.

Both the CN provider and the STRC provider will seek consent from the client to coordinate their care and ensure the client receives a seamless continuity of care.

More information on STRC can be found at the following link: www.myagedcare.gov.au/short-term-restorative-care.

See Section 3.2 referrals from hospitals and nurse practitioners for information relating to referrals to CN following a hospital stay.

13.5.10 State/Territory or local based community services
A CN provider can deliver CN services to a client with an assessed clinical need who is receiving State/Territory or local based community services, provided these services do not duplicate the provision of CN services. Where a client is in receipt of CN services as well as State/Territory or local based services, the providers must liaise to coordinate the care being delivered.
13.5.11 Communication with community support services
A CN provider must undertake, as a part of their CN role, the identification of a client’s need or changing need for other community support services.

If a CN provider identifies a client’s need for a community support services, it must refer the client to the appropriate services for an assessment.

When making a referral to a community support service the CN provider must:
• obtain the client’s consent for the referral;
• explain the reason for the referral;
• explain the type of service that the client is being referred to for an assessment; and
• explain to the client that making the referral does not guarantee that this service will be provided, as many of these services, including VHC, are resource limited and may have waiting lists.
Attachment A – Exceptional Case process

A small number of clients will have care needs that fall significantly outside the CN Schedule of Fees. To ensure these clients receive the CN services they require, they are assessed through the Exceptional Case (EC) process.

Effective 1 July 2021, prior approval must be sought from DVA through the EC process and an EC approval given before the commencement of care outside the Schedule of Fees. EC applications are reviewed by DVA clinical advisers. There will be no duplication of services between EC funding and a Home Care Package where this is in place. DVA is not liable to pay for any services that have been delivered before prior approval has been given.

Where urgent circumstances apply in regard to the commencement of care, the CN provider can contact DVA via secure email to exceptional.cases@dva.gov.au to outline the special circumstances. At DVA’s discretion, one off approval can be granted for up to ten working days to provide EC care without a comprehensive EC application. DVA will provide this approval in writing via secure email to the CN provider. Where this approval is granted, the CN provider is required to submit the EC application within two business days for assessment and processing by DVA.

The assessment of a client’s care requirements is based on their identified clinical needs at a specific point in time and approval will be given accordingly, for a maximum of 12 months. As care needs change over time, where appropriate, the funding will return to the Schedule of Fees. If further EC funding is required after 12 months, an EC application must be received 28 days prior to the expiry of the current EC approval. DVA is not liable to pay for any services that have not been given prior approval through the EC process.

Any client who has complex care needs and has potential EC status should undergo an aged care assessment by an ACAT assessor. The CN provider should facilitate this.

More information about ACAT assessments can be found at the following link: www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments.

1. Exceptional Case applications

It is the responsibility of the CN provider to submit a complete EC application signed by the RN, including all required attachments as detailed in the relevant EC form. If this information is not included with the application, a delay in processing the application will occur.

All applications must include:

- a copy of the current nursing care plan which must be signed by the RN and the client or authorised representative; and
- a GP Health Summary and referral, Specialist Referral or Hospital Discharge letter.
The nursing care plan must detail:

- the specific interventions required for each nursing need including frequency and whether the care is provided by an RN, EN or PCW;
- all medication interventions including if medication is being administered by an RN or assisted by a PCW. A current medication authority and/or medication chart signed by the treating doctor must be attached for administration of medications;
- any aids and appliances;
- the short and long term goals and objectives to successfully resolve and manage each identified nursing need;
- nursing equipment required to successfully complete interventions;
- level of personnel needed to successfully complete each planned intervention;
- referrals to allied health and other health professionals as clinically indicated;
- frequency and length of time needed for visits;
- agreed visit days and approximate timeframes;
- planned review dates as per Section 8 Review of Care requirements, and any additional requirements as identified from the nursing assessment; and
- nursing care plans should be signed by the RN and the client or their authorised representative.

If a client is identified as having potential EC status, the CN provider must maintain the existing 28-day claim date cycle for that client, rather than using a different start date in the application. Recording a different start date will result in delays in the assessment of the application and/or rejected claims for payment, as the 28-day claim cycle has not been maintained.

A CN provider can claim a Schedule of Fees item number whilst awaiting the outcome of an application for EC status

Application submission is via DVA secure email. Please email exceptional.cases@dva.gov.au to set up secure email facilities. Please refer to the below link for information about secure email: http://www.dva.gov.au/site-help/sensitive-emails

Enquiries relating to EC status can be emailed to exceptional.cases@dva.gov.au

1.1 Exceptional Case forms
The EC forms (listed below) are available online at the following link: https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/community-nursing/exceptional-cases.

Forms should be completed electronically where possible. If forms are completed manually, black pen should be used.
**Application for Exceptional Case status** – this form is used for new EC applications, including applications following the end of a 12 month approval period.

**Attachment 1 – Dementia** – this form is to be used as an attachment to an EC application where the client has been diagnosed with dementia.

**Attachment 2 – Mental Health** – this form is to be used as an attachment to an EC application where the client has been diagnosed with a mental health condition.

**Attachment 3 – Palliative Care** – this form is to be used as an attachment to an EC application where palliative care is being provided. It must include evidence of the involvement and oversight of the specialist palliative care team.

**Attachment 4 – Wound Care** – this form is to be used as an attachment to an EC application where wound care is being provided,

**Exceptional Case Interruption to Care** – this form is used to notify DVA of an interruption to a client’s EC care. This notification must be received within seven business days of the date the interruption to care commenced.

An interruption to care includes absences from home due to admission to an acute facility or hospice, a period of rehabilitation or residential respite, or going on a holiday.

If a client has an interruption to care during an agreed period of EC status, an adjustment may be made in the fee paid for the 28 day claim period during which the interruption to care occurred. If the client has been absent from care for more than 28 days, for whatever reason, they must be discharged from CN services. See Section 9 Discharge from Community Nursing Services.

**Exceptional Case Variation Form** – this form is used to notify DVA of a variation to a client’s care. This notification must be received within seven business days of the date the variation to care commenced.

**Request for Funding of Nursing Consumables over $1,000** – this form is used to apply for reimbursement of nursing consumables over $1,000 which cannot be claimed via the Schedule of Fees. See Attachment D Nursing Consumables. There is an upper limit of $1,500 per claim period for nursing consumables.

The application should include relevant attachment/s including itemised evidence of expenditure. If the consumables claim is in relation to wound care, the Attachment 4 – Wound Care form and current wound images must also be provided.
CN providers must not claim products that are contained in the nurse’s toolbox on this form. GST must not be included in the application. Any form that includes nurse’s toolbox products or GST will automatically be rejected and the CN provider will not be reimbursed until a correct form is submitted.

1.2 Application processing timeframes
DVA will endeavour to process EC applications within ten working days, to prevent unnecessary delays to the commencement of care.

Where applications are not completed in full, including necessary relevant attachments and other documentation, DVA will be unable to complete the assessment. DVA will make contact by secure email with the CN provider to notify them that the application is unable to be assessed and request the necessary information. The CN provider will have seven business days to submit the required information.

If the requested information is not provided within seven business days the provider will need to submit a new EC application.

It is the responsibility of the CN provider to supply a complete application with all relevant attachments in accordance with the requirements of the Notes. A new application for EC status can be made, if required, once all the required information is available.

1.3 Application assessment
DVA will assess an application to determine whether a client meets the requirements for EC status. The assessment will take approximately ten working days from receipt of a complete application.

A DVA representative may contact the CN provider to clarify and/or discuss the application.

In assessing an application, DVA will review:
- the client’s care needs;
- if the client’s care needs exceed the scope of the Schedule of Fees;
- the appropriateness of the client’s care regimen, including the skills mix of the personnel delivering the care; and
- whether the client’s care regimen will achieve realistic outcomes which include, as much as possible, a return to care levels which can be met under the Schedule of Fees.

1.4 Application outcome
DVA will notify the CN provider by secure email of the outcome of the EC application.

1.4.1 Application not approved
If the application is not approved, a reason why will be provided. Where DVA has determined that the client’s care needs can be managed within the Schedule of Fees, the EC application will not be approved.
If the CN provider has additional relevant information about the client which they wish to provide, they should contact DVA to discuss this information. DVA may reconsider the application in light of additional information.

1.4.2 Application approved
Where the application is approved, the approval letter will include:

- approval dates;
- the number of 28-day claim periods within the period of EC status, up to a maximum of 12 months;
- number of CN visits per 28-day claim period covered by the approval, for each level of personnel providing the assessed care;
- item number to be claimed for each 28-day claim period covered by the approval for the current calendar year; and
- fee to be paid for each 28-day claim period covered by the approval.

The first payment made for a client with EC status may include a component of Schedule of Fees as well as EC funding.

Indexation is applied to CN fees from 1 January each year. Following the indexation process, a subsequent approval letter will be sent for each existing EC approval that extends into the new calendar year, detailing funding information for the remaining claim periods covered by the approval.

CN providers should read the approval letter carefully and check all details. If there are any issues or queries identified, the provider should contact DVA immediately.

If DVA identifies the CN services being delivered do not meet industry recognised evidence based best practice, the approval will include required changes to these services which the CN provider must implement.

2 Appeals process
The EC process includes an appeals mechanism. In considering an appeal the CN provider must note that:

- a CN provider cannot appeal on financial grounds;
- an appeal can only be made when DVA has accepted that the client has EC status and that the required care falls outside the Schedule of Fees.

To lodge an appeal, the CN provider should forward in writing the reason for the appeal. The appeal should be lodged with:

Assistant Director Operations – Community Nursing via secure email to exceptional.cases@dva.gov.au

As part of reviewing an appeal, a clinical review may be conducted. The clinical review may include a documentation-based review and/or an in-home
assessment of the client’s care needs. If required, the in-home assessment will be undertaken by a health professional contracted by DVA.

2.1 Outcome of appeal
DVA will inform the CN provider of the outcome of the appeal within ten working days of receipt of the appeal. The appeal outcome is final.

If the appeal is upheld in full or in part, DVA will process a new approval based on the reviewed care needs. A letter detailing the new approval will be forwarded to the CN provider by DVA.

If the appeal is disallowed the original decision stands.

If the CN provider does not want to continue to deliver services to the client on the basis of the funding decision, DVA may consider transferring the client to an alternative CN provider if available. If an alternative CN provider is not available or DVA chooses not to transfer the client, the CN provider must continue to deliver the clinically appropriate CN services to the client.
Attachment B – Additional Travel

All Schedule of Fees and Exceptional Case classification item numbers have a built-in component for travel, including travel for multiple daily visits.

There are some circumstances where CN providers will deliver CN services to a small number of clients living in regional or remote areas who require an exceptional amount of travel that may not be covered by the Schedule of Fees and Exceptional Case classification item numbers.

To ensure that CN providers are adequately compensated for the travel to deliver CN services to these clients in regional or remote areas, an additional kilometre-based travel payment may be paid in certain circumstances.

1.1 Nearest suitable provider
A CN provider may not claim for travel for a client under the Additional Travel requirements if they are not the nearest suitable CN provider.

For Additional Travel purposes the nearest suitable provider also includes the location of its personnel. For example, one of the CN provider’s personnel may live closer to the client than the CN provider’s head office, in this case the CN provider’s personnel living closest to the client must be utilised to provide the care.

1.2 Situations where Additional Travel may be claimed
A kilometre-based travel payment is only paid when the following criteria are all met:
- the nearest suitable provider delivers the care;
- for travel only in regional or remote areas, classified under the Modified Monash Model (MMM) as regions MMM4 to MMM7; and
- for distances of 20 kilometres or more from the community nurse’s final departure point to the client’s home.

A kilometre-based travel payment is not paid:
- if the CN provider is already receiving additional travel for another client in the same region who is visited on the same day; or
- if there is another suitable provider closer to the client’s residence; or
- if the distance is less than 20 kilometres from the community nurse’s final departure point.

1.3 Claiming for Additional Travel
Additional travel can be claimed with the Schedule of Fees and EC items for the relevant 28 day claim period.

The Additional Travel item number must be claimed in conjunction with an item number/s from either the Clinical Care or Personal Care schedules or Exceptional Case status.
Additional travel is funded retrospectively. Claims should be submitted after the end of the relevant 28 day claim period, and within two 28 day claim periods of the end of the relevant 28 day claim period.

The CN provider should submit claims for payment to Medicare for the 28 day claim periods.

The Other Items – Additional Travel item number (NA10) will be used for reimbursement of the additional travel component only.
Attachment C – Palliative Care Phases

1. Palliative Care

Palliative care phases provide a clinical indication of the level of care required and have been shown to correlate strongly with survival within longitudinal, prospective studies.

The palliative care phase is a stage of the person’s illness. Palliative care phases are not sequential and a person may move back and forth between phases.

A client in the:
- Palliative - Stable phase of their disease, should not require high levels of interventions in this phase;
- Palliative - Unstable phase of their disease, requires high levels of interventions in the short term in this phase;
- Palliative - Deteriorating phase of their disease, requires high levels of interventions to enable them to remain at home in this phase; or
- Palliative - Terminal phase of their disease, requires interventions aimed at physical and emotional issues, and/or requires overnight nursing care in the short term and meeting the criteria to receive this overnight care.

REFERENCE DOCUMENT: Palliative Care Outcomes Collaboration (PCOC) University of Wollongong.

Phases are defined in terms of the following criteria as these highlight the essential issues to be considered when assigning a phase.

1.1 Phase 1: Stable

Symptoms are adequately controlled by established management. Further interventions to maintain symptom control & quality of life have been planned. The family/carer situation is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

1.2 Phase 2: Unstable

The person experiences the development of a new unexpected problem or a rapid increase in severity of existing problems, either of which require an urgent change in management or emergency treatment.

The family/carer experience a sudden change in their situation requiring urgent intervention by members of the palliative care team.

1.3 Phase 3: Deteriorating

The person experiences a gradual worsening of existing symptoms or development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

The family/carer experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of...
the person. This requires a planned support program and counselling, as necessary.

1.4 Phase 4: Terminal
Death is likely in a matter of days and no acute intervention is planned or required. The use of frequent, usually daily, interventions aimed at physical, emotional & spiritual issues is required.

The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

1.5 Bereaved
Death of a client has occurred and the family/carer are grieving. A planned bereavement support program is available including referral for counselling as necessary.

These phases are aligned with Palliative Care Australia’s national standards. Further information can be found on the Palliative Care Australia website at: http://palliativecare.org.au/.

## Psychosocial aspects of nursing care in the Palliative Phases

<table>
<thead>
<tr>
<th>PHASE</th>
<th>COMMON PSYCHOSOCIAL ASPECTS OF ADDITIONAL COMPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STABLE</strong></td>
<td>• Nursing care plans/advanced care plans</td>
</tr>
<tr>
<td></td>
<td>• Referrals for appropriate services/home supports</td>
</tr>
<tr>
<td></td>
<td>• Explore goals of care/treatment options</td>
</tr>
<tr>
<td></td>
<td>• Identify family/carer situation</td>
</tr>
<tr>
<td></td>
<td>• Assessment of psychosocial status</td>
</tr>
<tr>
<td></td>
<td>The symptoms are adequately controlled by an established plan of care and further interventions to maintain symptom control and quality of life have been planned and the family/carer situation is settled.</td>
</tr>
<tr>
<td><strong>UNSTABLE</strong></td>
<td>• Management of psychosocial crisis such as suicidal ideation or severe depression</td>
</tr>
<tr>
<td></td>
<td>• Family or carer crisis</td>
</tr>
<tr>
<td></td>
<td>• Emergency respite options</td>
</tr>
<tr>
<td></td>
<td>• Nursing care plan reviews to address unstable phase</td>
</tr>
<tr>
<td></td>
<td>• Referrals to appropriate services</td>
</tr>
<tr>
<td></td>
<td>The development of a new or unexpected problem or a rapid increase in the severity of existing problems requiring an urgent change in management or emergency treatment. The family/carers experience a sudden change in status requiring urgent intervention.</td>
</tr>
<tr>
<td><strong>DETERIORATING</strong></td>
<td>• Nursing care plan review to address deteriorating phase</td>
</tr>
<tr>
<td></td>
<td>• Counselling for family/carers</td>
</tr>
<tr>
<td></td>
<td>• Referrals to appropriate services</td>
</tr>
<tr>
<td></td>
<td>A gradual worsening of existing symptoms or the development of a new but anticipated problem that requires a specific nursing care plan. No urgent or emergency treatment is required. The family/carers have gradually worsening distress that impacts on the person’s care and may require planned support/counselling.</td>
</tr>
<tr>
<td><strong>TERMINAL</strong></td>
<td>• Increased support and counselling for family and carers</td>
</tr>
<tr>
<td></td>
<td>• Nursing care plan review to address terminal phase</td>
</tr>
<tr>
<td></td>
<td>• Increase in home visits</td>
</tr>
<tr>
<td></td>
<td>• Referrals to appropriate services</td>
</tr>
<tr>
<td></td>
<td>Death is likely in a matter of days. No acute interventions are planned.</td>
</tr>
</tbody>
</table>

Source: *University of Wollongong – Palliative Care Outcomes Collaboration – The Palliative Care Phase.*

The primary care team (the CN provider) usually provides the majority of the care under a palliative approach. Generally, a specialist palliative care team would not be directly involved in the ongoing care of clients who have uncomplicated needs associated with a life-limiting illness.

Specialist palliative care teams may be required to provide ongoing or episodic care when the problems experienced are complex, or beyond the capabilities of the primary care team. This scenario may vary depending on the State or Territory which the CN provider operates. If a CN provider has any concerns regarding palliative care, the CN provider or palliative care specialist should call DVA on 1800 550 457.
Attachment D – Nursing Consumables

1 Overview
The following information outlines the methods and processes that CN providers can use to obtain nursing consumables for clients.

1.1 Repatriation Pharmaceutical Benefits Scheme
There are a range of medications and wound dressings available through the Repatriation Pharmaceutical Benefits Scheme (RPBS). RPBS items require a prescription or authority prescription from a doctor.

The RPBS can be accessed online at www.pbs.gov.au/browse/rpbs.

1.2 Rehabilitation Appliances Program
The Rehabilitation Appliances Program (RAP) provides access to a range of aids or appliances to assist clients to maintain their independence at home. Aids or appliances prescribed through RAP can include for example:

- continence products;
- mobility and functional support aids;
- Personal Response Systems;
- home medical oxygen;
- diabetic supplies; and
- Continuous Positive Airways Pressure (CPAP) supplies.

Further information on RAP can be found on the DVA website at: https://www.dva.gov.au/providers/health-programs-and-services-dva-clients/rehabilitation-appliances-program.

1.3 Claiming for nursing consumables $1,000 and under
A range of Other Items - nursing consumables item numbers ($10 to $1,000) is available through the Schedule of Fees. These item numbers are exclusive of GST and are not subject to annual indexation.

1.4 Claiming for nursing consumables exceeding $1,000
All reimbursements for clients whose nursing consumables total cost exceeds $1,000 (exclusive of GST) in a 28-day claim period must be claimed via the EC process. See Attachment A Section 1.1 Exceptional Case forms – Request for Funding of Nursing Consumables Over $1,000. There is an upper limit of $1,500 for consumables per claim period.

Substantiation of items used, number supplied and cost in the 28-day claim period for each client must accompany the EC form.
1.5 Claiming rules
1. The CN provider claims the item number that is closest in value to the actual cost (excluding nurse’s toolbox items) within the listed range for nursing consumables provided to the client in a 28-day claim period.
2. The CN provider must not include any GST component when calculating which nursing consumables item number to claim. Payments made on behalf of DVA automatically add the GST component prior to payment.
3. The GST law allows a supplier and a recipient to agree to treat as GST-taxable any item listed in Schedule 3 that would otherwise be GST-free under the GST Act [subsection 38-45(3)]. To give effect to this arrangement, a CN provider that uses any of the nursing consumables item numbers will be taken to have accepted the GST-taxable status of these item numbers and to have agreed to the treatment of Schedule 3 items under subsection 38-45(3) of the GST Act. Schedule 3 items in supplies over $100 will continue to be GST-free.
4. DVA does not pay for the cost of delivery of nursing consumables to a client.
5. CN providers agree not to add any dollar amount or percentage or ‘mark-up’ on to the actual cost of the nursing consumables prior to claiming a nursing consumables item number.
6. CN providers agree not to claim for items that:
   - the client should purchase through a pharmacy or supermarket for ongoing non-clinical self-management of conditions (for example moisturiser, over-the-counter medication etc.);
   - the client has obtained via the RPBS;
   - the client has been supplied via RAP; and
   - items which are covered in the cost of the visit, including the ‘nurse’s toolbox’.
7. A nursing consumables item number can be claimed in conjunction with a clinical care item number or as a stand-alone item.
8. Only one nursing consumables item number can be claimed per 28-day claim period for a client.
9. MDS is not required for nursing consumables item numbers.
10. The CN provider must retain nursing consumables records on the client’s file to be able to substantiate any payment of nursing consumables item numbers for future Quality Framework review or Performance Monitoring review requests or processes.

1.6 Nurse’s toolbox
The ‘nurse’s toolbox’ consumables are:

| Adhesive remover wipes | Individual use lancing device |
| Alcohol wipes | Non-sterile gloves |
| Boot protectors | Non-sterile scissors |
| Disposable hand towels | Normal saline |
| Emergency use sharps container | Plastic apron/gown |
| Face masks | Sanitising hand wash |
| Gauze swabs | Skin protection wipes |
| Goggles | Tape |
Attachment E – Community Nursing and the Coordinated Veterans’ Care (CVC) Program
1 Overview
The Coordinated Veterans’ Care (CVC) Program is for Gold Card holders, including veterans, war widows/widowers and dependants who have one or more chronic conditions, and for White Card Holders for which DVA has accepted liability (an accepted mental health condition) which is chronic. To be eligible. All clients must have complex care needs and be at risk of unplanned hospitalisation.

The CVC Program is delivered in a General Practice setting and can involve just the GP, or in most cases the GP and a Coordinator. The Coordinator may be a Practice Nurse, Aboriginal and/or Torres Strait Islander Primary Health Worker, or community nurse working for a DVA contracted CN provider. The GP and Coordinator work together as a core Care Team, with the client and their carer if applicable. The Care Team may involve other health care providers who are delivering services to the client.

GPs will enrol eligible Gold Card holders and White Card holders with an accepted mental health condition in the CVC Program and support clients through the provision of comprehensive, coordinated and ongoing care with the assistance of a Coordinator. Eligible Gold Card holders and White Card holders with an accepted mental health condition who are enrolled in the CVC Program are referred to as participants.

The CVC Program is a team-based program encouraging partnership and collaboration between the participant, core care team of GP and Coordinator, and the health professionals and community supports involved in delivering services to the participant. The CVC Program involves a proactive approach to improve the management of participants’ chronic conditions and quality of care for participants.

Care Teams use a person centred approach to care planning, coordination and review as the model to support better outcomes and self-management of the client’s health. The program emphasises a coordinated approach, partnering and utilising a multidisciplinary team to provide tailored and flexible support based on the participant’s individual goals.

Through the CVC Program and the coordination of a participant’s comprehensive Care Plan (Care Plan), participants can access a wide range of health services to assist in the management of their chronic conditions. The sharing of health information amongst partnering health care providers enables better health outcomes for participants. Regular communication, empowerment and coaching are key to the Care Team successfully managing all aspects of the program for a participant.

1.1 Notes for Coordinated Veterans’ Care Program Providers

The *Notes for Coordinated Veterans’ Care Program Providers* define the parameters for providing health care treatment under the CVC Program to program participants and describe the relationship between DVA, the GP, the CVC Program participant and their carer (if applicable).

The Notes provide information about the delivery of the CVC Program for:

a) General Practitioners (GPs) and medical practitioners

b) Registered Nurses (RNs) / Enrolled Nurses (ENs) employed by the GP practice (Practice Nurses)

c) Aboriginal and/or Torres Strait Islander Primary Health Workers

d) Community Nurses employed by DVA contracted Community Nursing providers.

1.2 Community Nursing coordination component

Access to CVC coordination within the CN program is limited to those Gold Card holders and White Card holders with an accepted mental health condition who are participants in the CVC Program and have been determined by their GP as needing Coordination through a CN provider.

If a CN provider identifies that a Gold Card holder or White Card holder with an accepted mental health condition could benefit from enrolment in the CVC Program and is not participating in the CVC Program, they should recommend the client visit their GP to determine their eligibility.

1.2.1 Personnel

Coordination provided under the CVC Program:

- must be delivered by either an RN or an EN;
- in providing Coordination services under the CVC Program, the CN provider must ensure that the services are delivered by personnel with appropriate qualifications and experience;
- CVC Coordination activities delivered by an EN must be appropriately delegated, supervised and documented by an RN.

1.2.2 Record keeping

The CN provider must keep comprehensive clinical records in accordance with existing requirements in *Section 10.2 Care documentation*. This should include a copy of the CVC comprehensive Care Plan signed by the participant, GP and Coordinator.

Full details of all Coordination and contact activities must be recorded and placed on the participant’s file.

1.2.3 Claiming

All claims for payment for CVC Coordination services provided to a Gold Card holder or a White Card holder with an accepted mental health condition enrolled in the CVC Program are paid by Services Australia (Medicare) on behalf of DVA.

Once the GP assesses the Gold Card holder or White Card holder with an accepted mental health condition and enrols a patient in the CVC Program, the
GP’s quarterly care period commences and the GP Initial Assessment and Program Enrolment Payment is claimed through Medicare. After this claim is processed by Medicare, subsequent claims for CN Coordination services are able to be made.

1.2.4 Item numbers
The two CVC Program item numbers in the CN Schedule of Fees are:

1. UP05 – CVC Community Nursing – Initial Care Coordination is a one-off payment for the initial 28 day claim period in which the CN provider receives the CVC Program referral, appoints the CVC Coordinator, works with the GP to develop the comprehensive Care Plan and commences the CVC Coordination services.

This item must have a claim start date which is later than the date the Gold Card holder or White Card holder with an accepted mental health condition was enrolled in the CVC Program by the GP, and can only be claimed once in the life of a participant; and

2. UP06 – CVC Community Nursing – Subsequent Care Coordination is claimed for the provision of all subsequent 28 day CVC Coordination services.

When claiming the CVC Community Nursing – Subsequent Care Coordination item number, the CN provider should use the same 28 day claim period start date for all item numbers claimed for the same 28 day claim period for a Gold Card holder or a White Card holder with an accepted mental health condition, where the participant is also receiving CN services.

Where a Gold Card holder or a White Card holder with an accepted mental health condition is hospitalised during a claim period, the following rules apply:

- claims for Community Nursing – Subsequent Care Coordination services are still payable provided that some Coordination activity has taken place in the 28-day claim period; or
- claims for Community Nursing – Subsequent Care Coordination services are not payable if Coordination activity has not taken place in the 28-day claim period.

During hospitalisation, the Coordinator must:

- as a minimum, liaise with the GP to:
  - contact the hospital to advise that the Gold Card holder or White Card holder with an accepted mental health condition is a participant in the CVC Program and request to be advised of the expected discharge date; and
  - participate if possible in the hospital discharge planning process
- request a copy of the discharge papers from the GP;
- once discharged, contact the Gold Card holder or White Card holder with an accepted mental health condition to review the comprehensive Care Plan;
- document all Coordination activity in accordance with the existing requirements in Section 10.2 Care documentation.

NOTES FOR COMMUNITY NURSING PROVIDERS
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1.2.5 Death of a CVC Participant
Where a CVC participant dies partway through a claim period, the CN provider can claim the Community Nursing – Subsequent Care Coordination item number for the 28-day claim period in which the death occurred, provided some CVC Coordination activity has taken place in the 28-day claim period.

1.2.6 Entry into a Residential Aged Care Facility
The CVC Program is not available for permanent residents of an aged care facility. Where a CVC participant becomes a permanent resident of an aged care facility partway through a 28-day claim period, the CN provider can claim the Community Nursing – Subsequent Care Coordination item number for the 28-day claim period in which the participant entered residential care, provided some CVC Coordination activity has taken place in the 28-day claim period.

1.2.7 Temporary entry into a Residential Aged Care Facility
Where a CVC participant enters an aged care facility as a temporary resident for residential respite for all of a 28-day claim period, a Community Nursing – Subsequent Care Coordination item number cannot be claimed for this 28-day claim period.

1.2.8 Item numbers which cannot be claimed with CVC Program item numbers
The item numbers in the CN Schedule of Fees that cannot be claimed with a CVC Coordination item numbers are:
- NA02 – Assessment;
- NA99 – Assessment Only; and
- NL01 and NL02 – Clinical Support.

All Other Item numbers in the CN Schedule of Fees can be claimed in conjunction with the CVC Program Coordination Item Numbers, if appropriate.
Attachment F – Submitting Minimum Data Set (MDS)

1. **DVA Community Nursing MDS**

DVA requires CN providers to submit data on all the community nursing services delivered to a client. This data is referred to as the Minimum Data Set (MDS).

The MDS is used by DVA to monitor the appropriateness of the provision of community nursing services and ensure that a client receives quality health outcomes.

The MDS collects information on:
- **Claim Details:**
  - client’s name, file number and claim start date; and
  - item numbers claimed.
- **Staffing Resources Used (in the 28-day claim period):**
  - level of personnel delivering community nursing services to the client; and
  - visits/occurrences and hours of care provided by each level of personnel delivering community nursing services.

The MDS data is collected at the level of the individual client receiving community nursing services.

A CN provider must complete the MDS for every 28-day claim period that it delivers community nursing services to a client.

1.1 **Why does DVA require MDS data?**

DVA uses MDS data to:
- monitor the appropriateness of the provision of community nursing services;
- substantiate community nursing claims;
- ensure that a client receives quality health outcomes; and
- assist in research into program development (for example, MDS data was used in the development of the current Schedule of Item Numbers and Fees).

1.2 **What item numbers require MDS?**

All item numbers except nursing consumables (NC10 – NC70), Travel (NA10) and CVC Initial and Subsequent Care Coordination (UP05-UP06) require MDS.

1.3 **How is MDS recorded when a Registered Nurse undertakes both clinical and personal care in the one visit when a core and add-on are claimed?**

In instances where an RN/EN delivers clinical and personal in the same visit and a CN provider claims a core and add-on item, each component of the care delivered must be counted and recorded in the MDS as a separate occurrence.
There is possibility in one visit there may be multiple occurrences of services being delivered, e.g.:
- clinical care (core item);
- personal care (opposing schedule add-on); and
- palliative care (Other Items add-on).
- or vice versa:
- personal care (core item);
- clinical care (opposing schedule add-on); and
- palliative care (Other Items add-on).

1.4 Submitting MDS data
MDS data must be submitted at end of each 28-day claim period either:
- online to Services Australia (Medicare) as part of the Medicare claim (preferred); or
- manually by secure email to DVA, using the MDS Collection Tool.

If the CN provider has multiple sites with multiple provider numbers, each site must submit its own MDS data.

1.4.1 Online
CN providers are able to lodge claims for payment and MDS through Medicare’s online claiming, this is the preferred method for claiming and submitting MDS. CN providers who use online claiming to submit their claims include the MDS along with their submission.

1.4.2 Manual
The MDS Collection Tool is an Excel spreadsheet that is used to collect MDS Data manually.

If MDS data is not submitted in the format used by the MDS Collection Tool, or is incomplete, it will be returned to the CN provider for correction and resubmission.

1.5 The MDS Collection Tool Process
**Step 1:** Open the MDS Collection Tool.

**Step 2:** Once the MDS Collection Tool is open, save the MDS Collection Tool on your computer using your CN provider name* and the date that you commence completing it.
For example: If your provider name is “Tower Nursing Services”, and the MDS is completed on 1 November 2014, you would name the file as follows.

\[
\text{File name: Tower Nursing Services (1112014)}
\]

Note: There is a 35-character limit for MDS file names (including spaces). Please ensure each file name complies with the limit.

Once you have saved the MDS Collection Tool you can enter data.

1.5.1 Entering Information

The MDS Collection Tool is pictured below:

First, the following sections that need to be completed are:

- Provider Details;
- Claim Details; and
- Staffing Resources Used.

1.5.2 Provider Details
The Provider Details section collects information which allows DVA to:
- identify the CN provider and site submitting the data;
- seek further information (if required) from the CN provider’s MDS contact officer; and
- return data for resubmission if necessary.

1.5.3 Information required for Provider Details

Provider Business Name
This field requires you to enter your Provider Business Name as it appears on your DVA Community Nursing Agreement, however in some cases you may need to shorten the length to comply with the 35 character limit (including spaces).

Site Name (if applicable)
If CN providers have more than one site, enter the name of the relevant site, otherwise leave this field empty.

Provider Number
Enter the CN provider number for the site.

Contact name
Enter the name of the person who can assist with questions about the completed MDS Collection Tool.

Contact Phone Number
Enter the Phone Number for the contact person above.

1.5.4 Claim Details
Claim Details are recorded in the first four columns of the MDS Collection Tool, as shown below:

<table>
<thead>
<tr>
<th>Claim Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran File No.</td>
</tr>
</tbody>
</table>

The Claim Details section identifies the client, item number/s and the claim period to which the data relates. It is used to match MDS data to a claim.

If details are entered incorrectly, the data provided cannot be matched to a claim. The CN provider is not considered to have met their contractual obligations until data has been correctly matched to a claim.
1.5.4.1 Information required for Claim Details
All fields in the Claim Details section need to be completed for each row of data.

**NOTE:** A separate row of data must be entered for a client for each item number used during a 28-day claim period.

**File Number**
This field must contain the client’s file number written in exactly the same way as it appears on the client’s Gold or White Card.

**Veteran Surname**
This field must contain the client’s surname entered exactly the same way as it appears on the client’s Gold or White Card.

**Item Number**
The item number(s) must be recorded exactly as it was on the claim for the 28-day claim period.

The item number field includes a drop down menu that restricts entries to valid item numbers. CN providers can either enter a valid item number or use the drop down menu.

Where a client has more than one item number in a 28-day claim period, each item number must be recorded on a separate row.

**Error Message: Item Number**
If an invalid item number is entered into this field, the error message below will appear. Click on Retry and choose the correct item number from the drop down list.

<table>
<thead>
<tr>
<th><strong>Veteran File No.</strong></th>
<th><strong>Veteran Surname</strong></th>
<th><strong>Item Type</strong></th>
<th><strong>Item No.</strong></th>
<th><strong>Claim Period From</strong></th>
<th><strong>CNC Visits/Occurrences</strong></th>
<th><strong>CNC Hours</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>smith</td>
<td>VX123456789</td>
<td>Core_Personal</td>
<td>AB02</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Completing Claim Period From**
Dates must be entered in the DD/MM/YYYY format. This column requires the commencement date of the client's 28-day claim period. This must be the same date as recorded on the claim.

Where there is more than one item number for the 28-day claim period, the Claim Period From date entered must be the same for all item numbers claimed.

The template has been formatted to prevent an entry that is not in a date format, the message below will appear if an invalid date entry is made:

If this message appears, click on Retry and re-enter the correct date.

1.5.5 Staffing Resources Used (28-day claim period)

The Staffing Resources Used (28-day claim period) section records the number of visits and hours of service provided by each of the following personnel:
- Clinical Nurse Consultants (CNC);
- Registered Nurses (RN);
- Enrolled Nurses (EN); and
- Personal Care Workers (PCW).

This data is used to inform Community Nursing policy decisions including the setting of future item number fee levels and future directions for DVA's Community Nursing program. It is therefore important that the data provided is accurate.

1.5.5.1 Information required for Staffing Resources Used

Visits/occurrences - data for each type of personnel
CN providers are required to complete the number of visits/occurrences made by each type of personnel to a client within the 28-day claim period.

Minutes and Hours - data for each type of personnel
CN providers are required to enter the total number of minutes and hours of care provided by each type of personnel within the 28-day claim period.

Data must be entered in DECIMAL HOURS, for example:
5 minutes must be entered as 0.1 hours, 15 minutes must be entered as 0.25 hours and 150 mins as 2.5 hours. To assist, a conversion calculator is also included with the MDS Data Collection Tool.

For example:
During a 28-day claim period, a client receives:

- One 20 minute visit from a CNC:
  - 20 minutes divided by 60 minutes = 0.33 hours;

- Two visits from a RN, one takes 35 minutes and the other 45 minutes:
  - Add visits to get a total of 80 minutes; and
  - 80 minutes divided by 60 minutes = 1.33 hours.

- Three visits per week from a PCW which take 45 minutes each:
  - This makes 12 visits in the 28-day claim period;
  - 12 times 45 minutes = 540 minutes; and
  - 540 minutes divided by 60 minutes = 9 hours.
The correct entry for this example would be as follows:

<table>
<thead>
<tr>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNC Visits/ Occurrences</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

Error messages
If an invalid number is entered into these fields, an error messages will appear. Click on Retry and enter the correct number.

1.5.5.2 Information not required for Staffing Resources Used
The MDS Collection Tool indicates when an item number does not require Staffing Resources Used to be entered, a message appears as shown below:

<table>
<thead>
<tr>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Hours</th>
<th>RN Visits/ Occurrences</th>
<th>RN Hours</th>
<th>EM Visits/ Occurrences</th>
<th>EM Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NC37</td>
<td>01/10/2014</td>
<td>1</td>
<td>4</td>
<td>2.5</td>
<td>3</td>
<td>1.5</td>
<td>2</td>
<td>1.8</td>
</tr>
</tbody>
</table>

![CNC hours dialog box](image)

Your entry is not valid.
Enter the number of hours in the 28-day period. The number should be in hours.
This field restricts hours to a maximum of 250 per 28-day period.

No Nursing Hours/Visits Required for this Item
1.6 Scenarios when claiming a core and add-on

**Scenario 1**
Mr Brown is admitted to the nursing service on 1/10/14. The RN conducted the comprehensive assessment on the first home visit which took 1.5 hrs and Mr Brown receives clinical care nine times (this includes the comprehensive assessment) and personal care eight times in a 28-day claim period.

**Example A**
The provider delivers community nursing services to Mr Brown using an RN for seven visits for clinical care (including the comprehensive assessment), EN for two visits/occurrences (delivers both the clinical and personal care) and a PCW for six visits. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran File No.</td>
<td>Veteran Surname</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>BROWN</td>
<td>Core Clinical</td>
</tr>
<tr>
<td>BROWN</td>
<td>Other</td>
</tr>
<tr>
<td>BROWN</td>
<td>AddOn Personal</td>
</tr>
</tbody>
</table>

**Example B**
The provider delivers community nursing services to Mr Brown using an RN (nine visits in total) to deliver all the care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran File No.</td>
<td>Veteran Surname</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>BROWN</td>
<td>Core Clinical</td>
</tr>
<tr>
<td>BROWN</td>
<td>Other</td>
</tr>
<tr>
<td>BROWN</td>
<td>AddOn Personal</td>
</tr>
</tbody>
</table>
**Example C**
The provider delivers community nursing services to Mr Brown using an RN to conduct the comprehensive assessment, an EN to deliver the remaining clinical care and a PCW to deliver all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veteran File No.</strong></td>
<td><strong>Veteran Surname</strong></td>
</tr>
<tr>
<td>BROWN</td>
<td>Core Clinical</td>
</tr>
<tr>
<td>BROWN</td>
<td>Other</td>
</tr>
<tr>
<td>BROWN</td>
<td>AddOn Personal</td>
</tr>
</tbody>
</table>

**Scenario 2**
Mrs White is a war widow who requires daily personal care. She sustained a skin tear on day 18 of the 28-day claim period and required a combination of clinical (2nd daily) and personal care for the remaining period. Mrs White receives clinical care six times and personal care 28 times.

**Example A**
The provider delivers community nursing services to Mrs White using an RN for the all clinical care clinical care and a PCW for all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Veteran File No.</strong></td>
<td><strong>Veteran Surname</strong></td>
</tr>
<tr>
<td>WHITE</td>
<td>Core Personal</td>
</tr>
<tr>
<td>WHITE</td>
<td>AddOn Clinical</td>
</tr>
<tr>
<td>WHITE</td>
<td>CCCC</td>
</tr>
</tbody>
</table>
Example B
The provider delivers community nursing services to Mrs White using an RN to deliver both the clinical care and personal care on the visits where both services are required, the remaining personal care is delivered by a PCW. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran File No.</td>
<td>Veteran Surname</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>WHITE</td>
<td>Care Personal</td>
</tr>
<tr>
<td>WHITE</td>
<td>AddOn Clinical</td>
</tr>
<tr>
<td>WHITE</td>
<td>WC</td>
</tr>
</tbody>
</table>

Example C
The provider delivers community nursing services to Mrs White using an RN to assess and deliver the wound care in one visit as well as personal care, for the remaining visits where both clinical and personal care is required an EN delivered both, the remaining personal care is delivered by an PCW. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran File No.</td>
<td>Veteran Surname</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>WHITE</td>
<td>Care Personal</td>
</tr>
<tr>
<td>WHITE</td>
<td>AddOn Clinical</td>
</tr>
<tr>
<td>WHITE</td>
<td>WC</td>
</tr>
</tbody>
</table>

Scenario 3
Mr Gray is a veteran who requires twice a day visits for assistance with personal care. He has a Buprenorphine transdermal (e.g. Norspan) patch changed once a week.

Example A
The provider delivers community nursing services to Mr Gray using an RN to change the Norspan patch and a PCW to deliver all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Claim Details</th>
<th>Staffing Resources (Totals for 28 day Claim Period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran File No.</td>
<td>Veteran Surname</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>WHITE</td>
<td>Care Personal</td>
</tr>
</tbody>
</table>
### Example B
The provider delivers community nursing services to Mr Gray using an RN to change the Norspan patch and deliver personal care in the same visits/occurrences and a PCW to deliver all the remaining personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Visits/ Occurrences</th>
<th>CNC Hours</th>
<th>RN Visits/ Occurrences</th>
<th>RN Hours</th>
<th>EN Visits/ Occurrences</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Core Personal</td>
<td>N15</td>
<td>01/10/2014</td>
<td>4</td>
<td>2.67</td>
<td>52</td>
<td>34.66</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AddOn Clinical</td>
<td>NS01</td>
<td>01/10/2014</td>
<td>4</td>
<td>1.00</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Scenario 4
Mr Black has a deteriorating palliative condition and is receiving daily visits for a combination of personal care, medication administration (via a syringe driver), symptom management and psychosocial aspects of care. Personal care services take approximately 30 minutes per day. Clinical care including medication administration and symptom management 30 minutes per day and psychosocial care 15 minutes per day.

### Example A
The provider delivers community nursing services to Mr Black using an RN for the clinical and psychosocial care and a PCW delivers all the personal care. The MDS would be reflected as follows:

<table>
<thead>
<tr>
<th>Veteran File No.</th>
<th>Veteran Surname</th>
<th>Item Type</th>
<th>Item No.</th>
<th>Claim Period From</th>
<th>CNC Visits/ Occurrences</th>
<th>CNC Hours</th>
<th>RN Visits/ Occurrences</th>
<th>RN Hours</th>
<th>EN Visits/ Occurrences</th>
<th>EN Hours</th>
<th>NSS Visits</th>
<th>NSS Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Care Clinical</td>
<td>NL17</td>
<td>01/10/2014</td>
<td>29</td>
<td>14.00</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>AddOn Personal</td>
<td>NT14</td>
<td>01/10/2014</td>
<td>28</td>
<td>7.00</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>Other</td>
<td>NA06</td>
<td>01/10/2014</td>
<td>28</td>
<td>7.00</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example B
The provider delivers community nursing services to Mr Black using an RN to deliver all Mr Black’s care needs. The MDS would be reflected as follows:

1.7 Checking MDS Collection Tool is complete
The MDS Collection Tool indicates if a row of data is missing a field by showing the font as red.

The example below is missing the “Claim Period From” and “CNC Hours (total)” data.

When data has been entered correctly, the font will change to black:

Once all the data has been entered the MDS can be submitted.
1.8 Submitting finalised data for manual MDS

1.8.1 SENSITIVE email

DVA’s Secure Mail Facility (Sensitive email) has been introduced to enable the secure communication of sensitive information between DVA and external parties over the internet.

Sensitive emails sent via this facility are encrypted to ensure the information within each email remains private and secure. Encrypting the email means the contents are scrambled/encoded to minimise the risk of an unauthorised person being able to read it if it is intercepted.

1.8.2 Registering an email address

A CN provider is required to register an email address in order to submit their MDS through Sensitive email. The Contractor’s Representative (as recorded on the Agreement held with DVA) is first required to email the following information regarding the person who will be submitting the MDS (MDS contact):

- MDS contact name;
- Contact phone number; and
- Email address used to submit the MDS.

This information should be emailed to mds@dva.gov.au.

DVA will respond to the MDS contact/s providing information on how to use Sensitive email. Once the MDS contact/s have read the information and replied to DVA, arrangements will be made to commence communication via Sensitive email.

The first time you receive a Sensitive email, you will be asked to:

1. Open the attachment to the email; and
2. Follow the instructions.

Open the attachment to the email that is called ‘SecureMessageAtt.html’:

A new browser window will open. Click the ‘Read Message’ button (the button is in the middle of the page):
You will then be prompted to register:

- enter your first and last name;
- create a password and re-confirm the password; and
- enter a ‘Password Recovery Question’. The recovery question will assist you if you forget your password.

**Registration**

![Registration Form]

Email Address: MGS@alva.gov.au

<table>
<thead>
<tr>
<th>Field</th>
<th>Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Joe</td>
</tr>
<tr>
<td>Last Name</td>
<td>Blogs</td>
</tr>
<tr>
<td>Password</td>
<td>**********</td>
</tr>
<tr>
<td>Confirm Password</td>
<td>**********</td>
</tr>
<tr>
<td>Password Reset</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Father's middle name</td>
</tr>
<tr>
<td>Answer</td>
<td>Burt</td>
</tr>
</tbody>
</table>

[Continue Button]
Passwords must meet certain conditions:

- Passwords must be 6-20 characters long.
- At least one digit (0-9) is required.
- At least one symbol character is required.
- Your username may not appear in the password.

An example password is: Pa55w@rd

Upon successful login, the Sensitive email will be displayed in the browser window.

1.8.3 Emailing the MDS Collection Tool
Open the Sensitive email from DVA that will appear in your mailbox with a ‘from’ address mds@dva.gov.au and will have a classification of DLM=Sensitive:Personal.

Open the Sensitive email from your mailbox and the attachment to the email that is called ‘SecureMessageAtt.html’:
A new browser window will open, click the ‘Read Message’ button:

![Read Message Button](image)

You have received a secure message from the Department of Veterans’ Affairs. To read the secure message, click the button above. If you are a first time user, you may have to take additional steps.

Secured by Proofpoint Encryption, Copyright © 2009-2012 Proofpoint, Inc. All rights reserved.

Click the ‘Reply’ button (the button is located at the top left) to reply only to the address that sent you the email:
When replying to a Sensitive email, please ensure the subject field is not changed. To attach the MDS Collection Tool spreadsheet click on ‘Attach a File’ as below:

Locate the MDS Collection Tool spreadsheet in your records and attach the MDS Collection Tool spreadsheet by highlighting and clicking on the ‘+ ADD’ button, and tick ‘Send me a copy’.
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EFFECTIVE JULY 2021

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Once the MDS Collection Tool spreadsheet has been located, click on the ‘Upload’ button:
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EFFECTIVE JULY 2021

The uploaded MDS Collection Tool spreadsheet will be displayed:

Repeat the previous steps if there is more than one spreadsheet to be uploaded. Once all files are attached click on the 'Send' button:
Once the Sensitive email has been sent, the following message will appear:

**Message Sent**

- Your secure message was sent successfully.
- To exit click Logout or close this browser window.

Click the ‘Logout’ button, this will securely log you out of the secure session:

**Logged Out**

- You are now logged out and can close this browser window.

Note: The MDS contact must keep the original Sensitive email sent by the DVA to reply to DVA each month.

All MDS submissions to DVA must be sent DLM=Sensitive:Personal to ensure compliance with the Commonwealth Information Privacy Principles Legislation.

1.8.4 Who do I contact if I have a problem?
If this information is unable to assist you, and the problem or question is technical in nature, you can send an email to **secure.services@dva.gov.au**. Please let DVA know how to contact you regarding your query.

Do not disclose your password or password recovery answer in this email. DVA will not ask you for your password or password recovery answer.

1.8.5 Password resets
If you cannot remember the answer to your ‘Recovery Question’ you will need to contact DVA on either 1300 301 575 or **secure.services@dva.gov.au** to reset the password.

1.8.6 Resubmits
If MDS data is submitted incorrectly, it will be returned via an email identifying the issues. CN providers are required to correct and resubmit the data within 28 days. When resubmitting data, the CN provider is required to mark the data clearly as resubmit.