



Australian Government
Department of Veterans' Affairs

Notes for Community Nursing providers

Effective March 2025

* This version of the Notes includes two temporary provisions that are in place to 30 June 2025, and one temporary provision in place to 30 June 2026.

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1 Introduction

The Community Nursing Program is administered under the *Treatment Principles* for both the *Veterans' Entitlement Act 1986 (VEA)* and the *Military Rehabilitation Compensation Act 2004 (MRCA)*. The Treatment Principles set out the circumstances under which financial responsibility is accepted for community nursing services delivered to eligible Department of Veterans' Affairs (DVA) clients.

In the event of an inconsistency between the Notes and the Treatment Principles, the Treatment Principles prevail. Any breach of the Notes may lead to an action in accordance with the Treatment Principles, such as non-payment of claims or recovery of monies from claims previously paid.

The DVA Community Nursing Program contract is a legally binding Agreement, comprising the [Terms and Conditions for the provision of Community Nursing Services](#) (Terms and Conditions), the [Notes for Community Nursing providers](#) (the Notes), and the [Community Nursing Schedule of Fees](#) (Schedule of Fees), setting out the conditions and accountability requirements under which Community Nursing providers may provide services to clients under DVA health care arrangements.

The Notes is **Annexure A** to the Terms and Conditions. The Community Nursing provider and all personnel delivering community nursing services to clients must read, understand and comply with the Notes, which are non-negotiable.

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

- face-to-face time
- travel time
- general time
- labour on-costs
- overheads
- profit margin
- ['nurse's toolbox'](#) consumables.

Changes applied to the Schedule of Fees, including indexation, take effect for claim periods commencing on or after the date the change is applied.

To remain contemporary, the Notes will be amended periodically. DVA will publish updated versions of the Notes on AusTender, and on the DVA website at [Information for DVA contracted community nursing providers](#).

This version of the Notes includes three temporary provisions:

- [Section 6.4.1 – Remote Delivery of Clinical Wellbeing Checks](#) (in place until 30 June 2025)
- [Section 8.2.1 – Temporary changes to 28 day reviews](#) (in place until 30 June 2025)
- [Section 1.1.1 – Sustainability Payments](#) (in place until 30 June 2026).

1.1 SERVICES AND PAYMENTS

DVA provides clients with access to a range of quality health care and related services, including community nursing services, at DVA's expense.

Information about DVA services can be found online at <https://www.dva.gov.au>.

DVA will fund community nursing services delivered to entitled persons by a contracted Community Nursing provider. Entitled persons are eligible DVA Veteran Gold or White Card holders. For the purposes of the Notes, entitled persons are referred to as clients.

1.1.1 Sustainability Payments

Between 1 July 2024 and 30 June 2026, DVA will provide sustainability payments to DVA contracted Community Nursing providers, in recognition of increasing market pressures, enabling continuity of services for the veteran community. This funding is in addition to existing payments for services made under the Schedule of Fees.

Sustainability payments will be payable on a quarterly basis, calculated on the unique number of clients per month for whom providers received payment in the previous quarter, for services delivered under the Community Nursing Program. DVA will communicate the amount payable each quarter to providers, with invoices submitted by providers to DVA to enable the payment to be made.

1.2 PROVIDER NUMBER/S

DVA allocates Community Nursing 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 can email the DVA contract manager at Community.Nursing.Contracts@dva.gov.au.

1.2.1 Changes to service delivery areas or sites

A Community Nursing provider will supply DVA with information related to changes to service delivery areas or sites within 30 days. 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.

1.3 SUBCONTRACTING

Community Nursing providers intending to utilise a subcontracted organisation to provide community nursing services are required to:

- ensure the subcontracted organisation is an appropriate service provider, i.e. not a sole trader or individual
- notify DVA within 30 days in the event of any subcontracted organisation being used to deliver community nursing services to clients by completing the subcontracting template
- identify subcontracted organisations 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 when requested, and supply DVA with a signed copy on request
- ensure that subcontracted organisations employ suitably qualified and competent personnel to deliver services, as per the requirements set out in [Section 4 – Human Resources](#)
- ensure subcontracted organisations have an employee code of conduct that personnel adhere to
- ensure subcontracted organisations have access to the Notes and any other DVA material required for them to deliver services in accordance with DVA requirements
- inform subcontracted organisations of the obligations and the conditions and accountability requirements contained in the Agreement between DVA and the Community Nursing provider, as relevant
- ensure that, in providing their services, subcontracted organisations are made aware of and comply with the DVA Service Charter
- inform subcontracted organisations that DVA has the right to request and review documentation related to services provided to clients under the subcontract, including as part of any audit process undertaken by DVA of the Community Nursing provider
- ensure the continuing suitability of subcontracted organisations, including compliance with law generally and anti-discrimination laws
- ensure no subcontract restricts DVA's legal rights
- appropriately pay or remunerate subcontracted organisations under any relevant subcontract, including accounting properly for all tax-related matters
- ensure every subcontract contains clauses that impose obligations on the subcontracted organisation and grant rights to DVA (either directly or through the Community Nursing provider) that are the same as those obligations imposed on the Community Nursing provider and those rights

granted to DVA under these Notes and the Terms and Conditions applicable to the part of the services being provided by the subcontracted organisation

- agree that none of the following reduce or limit the Community Nursing provider's obligations under the Agreement:
 - the Community Nursing provider subcontracting any part of the services delivered under this agreement
 - an act or omission of a subcontracted organisation.

The subcontracting template can be found at [How to become a DVA contracted Community Nursing provider](#) on the DVA website.

1.4 ACCESS TO THE NOTES

A Community Nursing provider must ensure all of its personnel and any subcontracted organisations delivering community nursing services to clients have access to, and a working knowledge of, the current Notes, including any amendments made to the Notes over time.

1.5 CONTACTING DVA

A Community Nursing provider can contact the DVA Provider Enquiry Line by telephone on 1800 550 457.

Written enquiries can be emailed to the following areas:

- general Community Nursing Program information including interpretation/clarification of program policies contained in the Notes: nursing@dva.gov.au
- Exceptional Cases: exceptional.cases@dva.gov.au
- enquiries about community nursing quality and compliance and reviews: CN.program.quality@dva.gov.au
- matters relating to the contract: Community.Nursing.Contracts@dva.gov.au
- client eligibility checks: health.approval@dva.gov.au (or via phone on the provider enquiry line above)
- enquiries about Sustainability Payments: dva.sustainability.payments@dva.gov.au

Information about the Community Nursing Program can be found online at [Community nursing services and providers](#).

1.6 FEEDBACK / COMPLAINTS MECHANISM

A Community Nursing provider can provide feedback, including complaints, about any aspect of the Community Nursing Program by emailing nursing@dva.gov.au or online at [Complaints, compliments and other feedback](#).

DVA will review all feedback and complaints and inform the complainant of the outcome of their complaint.

As DVA is not a registration or regulatory authority, there may be instances where DVA will need to refer the complaint to the one of the following bodies due to the nature of the complaint:

- the Australian Health Practitioner Regulation Agency (Ahpra)
- a relevant peak professional body
- a state / territory health complaints organisation.

2 Aim and scope of the Community Nursing Program

The aim of the DVA Community Nursing 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 community nursing services that meet the client's assessed nursing needs. Nursing services include both clinical and personal care services required to meet a defined health outcome. DVA contracts Community Nursing providers to deliver these nursing services to clients in their own homes.

Community nursing services are delivered by Registered Nurses (RN), Enrolled Nurses (EN), and Personal Care Workers (PCW).

A Community Nursing provider must:

- deliver community nursing services in line with industry recognised evidence based practice and quality standards
- assist a client to develop, increase or maintain their independence, health and wellbeing.

2.1 CARE ENVIRONMENT

The care environment for DVA funded community nursing services is the client's home (or place of residence, excluding locations listed under [Section 2.3 - Out of Scope](#)).

A Community Nursing provider must:

- deliver all community nursing services to a client face-to-face in their home. 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 relevant Schedule of Fees item
- conduct an assessment of any environmental risks to the safety of the Community Nursing provider personnel or client in the delivery of services in the client's home. If any environmental risks are identified, the Community Nursing provider must discuss the risks and options to mitigate those risks with the client and/or their carer, and note in the care documentation
- deliver community nursing services in a safe, effective and responsive manner to facilitate positive outcomes for the client, and in a manner that promotes privacy, dignity and respect for the client, including taking into account the client's culture and diversity
- deliver community nursing services in accordance with the nursing care plan
- provide a contact for clients for emergency purposes 24 hours a day, 7 days a week.

2.2 SCOPE OF THE COMMUNITY NURSING PROGRAM

The Community Nursing Program provides a primary care service that aims to support the general health of a client with low risk, simple clinical interventions. It 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 Community Nursing Program is not a hospital substitution service or part of a hospital substitution service.

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 community nursing 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

A Community Nursing provider *cannot* deliver community nursing services to a client in any of the following locations as they are out of scope for the Community Nursing Program:

- an acute care facility (including hospital in the home programs)
- a residential aged care facility
- a multi-purpose centre
- a community centre
- a clinic in any location.

If a client chooses to access, or a Community Nursing provider chooses to deliver, services in a facility or clinic instead of the client's home, then the provider cannot claim for payment for these services from DVA.

Hospital substitution services including Hospital in the Home are out of scope for the Community Nursing Program.

The Community Nursing Program does not provide in-home respite care or supervision nor provide services to meet needs associated with Instrumental Activities of Daily Living (IADLs). These services are out of scope for the Community Nursing Program. Where ADLs and IADLs are assessed through one tool, only the identified ADLs should be supported through community nursing services.

IADLs can be supported through the DVA Veterans' Home Care (VHC) Program or another suitable program. If a care need relating to an IADL is identified, the client can be referred to a Veterans' Home Care (VHC) Assessment Agency for assessment for services that can be provided under the VHC Program.

Additional care needs outside the scope of the Community Nursing Program may be covered under another program such as the Department of Health and Aged Care (DHAC) funded Home Care Packages (HCP) Program or Commonwealth Home Support Programme (CHSP). The client can be referred to My Aged Care for an assessment.

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
- managing finances.

Where identified services are out of scope for the Community Nursing Program (for example respite care, supervision, or meal preparation), a Community Nursing provider should not misrepresent to a client what can be provided under the Community Nursing Program even if this does not align with the client's expectations. The Community Nursing provider could discuss alternative service options with the client as required and/or refer to the GP or alternative services.

Community nursing services are to maintain 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. Additionally, where clients are receiving similar services through another program, there must be no duplication of services between the programs.

3 Access to the Community Nursing Program

3.1 ELIGIBILITY

A client is a person to whom DVA has issued a:

- Veteran Gold Card (clinically required treatment for all medical conditions) or
- Veteran White Card (medical treatment for accepted service-related injuries or conditions).

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

3.1.1 Veteran Gold Card

The Veteran Gold Card is gold in colour and includes the words: "Veteran – All Conditions within Australia".

A Veteran 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.

3.1.2 Veteran White Card

The Veteran White Card is white in colour and includes the words: "Veteran – Specific Conditions".

For all Veteran White Card holders, **the community nursing provider must contact DVA** to determine eligibility to receive community nursing services for an assessed clinical nursing and/or personal care need prior to the commencement of community nursing services. See [Section 1.5 – Contacting DVA](#).

Community nursing services can only be provided to meet clinically required nursing care needs associated with a client's eligibility to receive treatment, including for an accepted condition, or under Non-Liability Health Care (NLHC) or Provisional Access to Medical Treatment (PAMT). NLHC covers the cost for eligible veterans for treatment of a mental health condition, cancer (malignant neoplasm), and pulmonary tuberculosis, where services work towards treating those condition/s.

If a client is receiving services under PAMT and their claim is declined, their eligibility to receive services will end.

See the [Veteran White Card](#) and [Cancer and pulmonary TB care](#) pages on the DVA website for further information about Veteran White Card holder eligibility to receive services.

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 provides access to prescription medicines, wound care items and nutritional supplements at a concessional rate through the Repatriation Pharmaceutical Benefits Scheme (RPBS) for eligible Commonwealth, allied veterans or mariners.

The card cannot be used to access any community nursing services.

3.2 REFERRALS

A Community Nursing provider must receive a valid written referral for an eligible client before the commencement of services, from one of the following authorised referral sources:

- General practitioner (GP)
- Treating medical practitioner in a hospital
- Hospital discharge planner
- Nurse practitioner specialising in a community nursing field.

Note: The client's GP is to have ongoing clinical oversight of the person's care. See [Section 8.5 – Communication with the client's GP](#) for expectations around communication between the Community Nursing provider and GP.

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

Referrals from GPs and nurse practitioners are valid for 12 months, at which time a new referral is required.

Referrals from hospitals are valid for six weeks, see [Section 3.2.2 – Referrals from Hospitals](#) for more information.

A Veterans' Home Care (VHC) Assessment Agency may identify a need for community nursing services and refer the client to their GP for a community nursing referral.

A Community Nursing provider cannot represent itself in any way as a DVA preferred provider.

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

3.2.1 Written referral requirements

The authorised referral source must provide a written referral for a client to a DVA contracted Community Nursing provider to request community nursing services. The referral should be on either the referral source's official letterhead, the Community Nursing provider's referral form, or the [DVA Community Nursing referral form](#), and be sent directly to the Community Nursing provider.

The referral must include the following information:

- authorised referral source details, including provider number (for a referral from a discharge planner or treating medical practitioner in a hospital, the hospital's provider number must be used)
- the medical condition/s the client requires community nursing services for, and clinical details of the condition/s including recent illnesses 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 client'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 to eat is required, a nutritional assessment must also be conducted to determine the nutritional risk
- other health / support services the client is receiving
- whether an Aged Care assessment (through the Department of Health and Aged Care) has been conducted, and the outcome of any assessment.

3.2.2 Referrals from hospitals

Where a referral is received from a hospital (treating medical practitioner or discharge planner) following a client's stay in hospital, the referral is valid for a period of six weeks post discharge. An updated referral is required from the client's GP to cover care needs beyond the six week 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 services such as DVA's convalescent care, or the Department of Health and Aged Care (DHAC) Transition Care Programme. A Community Nursing provider should discuss the most appropriate program / service for a client with the hospital discharge planner prior to accepting a referral. Information about DVA's convalescent care is available on the DVA website at [Convalescent care](#). See [Section 12.4.4 - Transition Care Programme](#) for further information about the DHAC Transition Care Programme.

3.2.3 Referral to a Community Nursing provider

An authorised referral source should refer a client to a suitable Community Nursing provider in the same geographic region as the client's home. Providers can be identified from the panel located on the DVA website at [Panel of Community Nursing providers](#).

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

3.2.4 Referral period

Hospital referrals are valid for six weeks, following which time an updated referral from the client's GP will be required to cover ongoing care needs.

A referral from a GP or nurse practitioner specialising in community nursing is valid for a period of 12 months. If a client is admitted for less than 12 months the referral remains valid through the client's episode of care from admission to discharge.

A new referral from the client's GP or nurse practitioner specialising in community nursing is required:

- when a client is transferred to another Community Nursing provider
- when a client is discharged from community nursing services and later readmitted
- at the end of every 12 month period where ongoing services continue to be required.

3.2.5 Informal enquiry

An informal enquiry or request for services may be received from a number of sources, such as a client, a family member / carer or a concerned neighbour.

If an informal enquiry is received, the Community Nursing provider must advise the person to contact the client's GP (or other authorised referral source), to obtain a written referral. The written referral is required prior to the commencement of community nursing services.

3.2.6 Acceptance of a referral

A Community Nursing provider should accept a referral for a client from an authorised referral source, including on the transfer of a client.

Where a referral is unable to be accepted, the Community Nursing provider must immediately notify the referrer verbally and in writing to advise the referral will not be accepted and the reason/s why.

3.3 TRANSFER OF A CLIENT

A Community Nursing provider cannot transfer a client to another Community Nursing 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 1.5 – Contacting DVA](#).

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

Where a client transfers to another Community Nursing provider, e.g. due to client choice or moving to another location, the transfer can take place with the oversight of the client's GP, and without disruption to the client's community nursing services. DVA does not need to be advised of a transfer where it occurs due to client choice.

A new referral from the client's GP will be required if a client is transferred to another Community Nursing provider.

3.4 INFORMED CONSENT

A Community Nursing provider must obtain written informed consent from the client before commencing community nursing services. If the client is unable to give their consent, a nominated representative (i.e. a person authorised to represent the client, including under a guardianship or administration order, Power of Attorney, legal representative etc.) may consent on their behalf.

To ensure the client can make an informed choice about the proposed community nursing services, the Community Nursing provider must discuss and provide the client with information including:

- a verbal and written explanation of the proposed community nursing services to be delivered, in a way the client understands
- their rights and responsibilities as a client
- the role of the Community Nursing provider's personnel, and that different personnel may be providing community nursing services depending on clinical requirements and staff availability
- the possibility that personal information about them may need to be disclosed to other health providers, as clinically appropriate, by the Community Nursing provider, 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 Community Nursing provider, including their care documentation
- the process for providing feedback or making a complaint about the community nursing services they receive.

3.5 DATE OF ADMISSION

The date of admission to the Community Nursing Program is the date of the first face-to-face contact visit between a Community Nursing 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 place of home.

4 Human Resources

4.1 PERSONNEL

A Community Nursing provider may use a mix of personnel to deliver community nursing services. These personnel include:

- Registered Nurses (RN)
- Enrolled Nurses (EN)
- Personal Care Workers (PCW).

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

Community Nursing providers are responsible for the appropriate supervision, training and support of all personnel delivering services to clients, and must ensure all personnel have the required qualifications, experience and competencies.

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

Community Nursing providers must ensure all personnel have relevant qualifications, current registration, competencies, experience and screening checks, and continue to meet continuing education requirements. This information must be maintained by Community Nursing providers for all their personnel, including current registration and continuing education documentation.

Community Nursing providers must ensure that all personnel and personnel of subcontracted organisations who have access to clients have had either:

- a national police check within the last three years, or
- if working for a provider registered to deliver services under the National Disability Insurance Scheme (NDIS), an NDIS worker screening check in the last three years.

Staff must also hold a working with vulnerable people registration / clearance or State / Territory equivalent, where this is a requirement for the delivery of services to adults in the State / Territory in which services are being delivered.

Community Nursing providers must have systems and processes in place for the orientation and induction of new staff. DVA has a suite of educational resources for Community Nursing providers on the DVA website at [Training and resources for Community Nursing providers](#).

4.2 REGISTERED NURSES (RN)

The national standards developed by the Nursing and Midwifery Board of Australia (NMBA) provide the framework for professional nursing practice in Australia.

Information on the national standards for RNs and ENs and Code of Conduct for nurses can be accessed online through the '*Professional Codes & Guidelines*' tab on the NMBA website, at www.nursingmidwiferyboard.gov.au.

RNs providing community nursing services must have:

- current registration with the Australian Health Practitioner Regulation Agency (Ahpra), with no restrictions to practice
- a minimum of one year supervised post-registration practice (however a minimum of two years' post graduate experience including wound management is recommended)
- completed infection prevention and control training
- medication management competency
- current manual handling competency
- current Basic Life Support (BLS) certification.

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

RNs are responsible for:

- comprehensively assessing client nursing care requirements, face-to-face in the client's home including a holistic review of the client's health
- reporting the outcomes of the assessment to the client's GP
- developing a tailored nursing care plan informed by the comprehensive assessment
- delegating aspects of client care to ENs and PCWs according to their respective role, scope of practice, competencies and capabilities
- monitoring, supervising and providing assistance as and when required to ENs and PCWs
- ensuring clinical progress notes and assessment documentation are legible, current and based on industry best practice standards
- documenting all delegation of care in the client's clinical records
- providing community nursing care and services in accordance with the RN's position description and the *Registered Nurse standards for practice* developed by the NMBA, which can be found at [NMBA – Registered Nurse Standards for Practice](#).

4.3 Delegation of care

A Community Nursing provider must ensure that all community nursing 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 in the client's file.

The RN must recognise the differences in accountability and responsibility between RNs, ENs and 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
- delegation to and supervision of others consistent with legislation and organisational policy.

More information about delegation of care can be found in the *Registered Nurse standards for practice* at [NMBA – Registered Nurse Standards for Practice](#).

4.4 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.

Information on the national standards for RNs and ENs and Code of Conduct for nurses can be accessed online through the '*Professional Codes & Guidelines*' tab, on the NMBA website, at www.nursingmidwiferyboard.gov.au.

ENs providing community nursing care and services must have:

- current registration with the Australian Health Practitioner Regulation Agency (Ahpra), with no restrictions to practice
- a minimum of one year supervised post-registration practice (however a minimum of two years' post graduate experience including wound management is recommended)
- completed infection prevention and control training
- current manual handling competency
- current Basic Life Support (BLS) certification
- medication management competencies (where applicable) and
- delegation by an RN to provide community nursing care and services, in accordance with the EN's position description.

Care and services should also be provided in line with the *Enrolled Nurse standards for practice* developed by the NMBA, which can be found at [NMBA - Enrolled nurse standards for practice](#).

All community nursing services delivered by an EN must be planned, delegated and supervised by an RN. All delegated care must be appropriately documented in clinical records and kept in the client's file, in line with the requirements set out under [Section 4.2.1- Delegation of care](#).

4.5 PERSONAL CARE WORKERS (PCW)

The Community Services Training Package developed by HumanAbility forms a training and assessment framework for the certification of PCWs. Information about the Community Services Training Package can be accessed online at <https://training.gov.au/Training/Details/CHC>.

All community nursing services provided by PCWs must be in accordance with the relevant standards and qualifications included in the Community Services Training Package, or equivalent training.

PCWs delivering community nursing services to a client must hold one of the following qualifications:

- a Certificate III in Home and Community Care, Aged Care or Disability (pre-December 2015)
- a Certificate III in Individual Support (post December 2015)
- a Certificate III in Health Services Assistance
- a student in the second or third year of Bachelor of Nursing degree at an Australian university or accredited higher education provider.

PCWs must also have:

- completed infection prevention and control training
- medication assistance competency (where applicable)
- current manual handling competency
- current Basic Life Support (BLS) certification
- current Provide First Aid certificate.

These competencies must be maintained and recorded in personnel files.

Community Nursing providers must ensure all personnel employed as PCWs are appropriately skilled and experienced to deliver community nursing services, and receive appropriate training and support.

All community nursing services delivered by a PCW must be planned, delegated and supervised by an RN. All delegated care must be appropriately documented in clinical records and kept in the client's file, in line with the requirements set out under [Section 4.2.1- Delegation of care](#).

4.6 COMPETENCIES AND TRAINING

All personnel must regularly receive competency-based training in relation to core matters, including at a minimum:

- the delivery of person-centred, rights-based care
- culturally safe, trauma aware and healing informed care
- caring for people living with dementia
- responding to medical emergencies.

4.6.1 First Aid, Basic Life Support and Manual Handling competency requirements

First Aid and Basic Life Support (BLS):

- Competencies for First Aid and BLS must be completed by personnel annually.
- Nationally recognised qualifications must be issued **every 3 years by a Registered Training Organisation (RTO)** with personnel receiving a certificate of competency for First Aid and BLS units completed.
- Annual refreshers for both First Aid and BLS, in between the 3 year RTO qualification, can be completed by qualified First Aid and BLS trainers with a Cert IV Training and Assessment qualification.

Manual Handling:

- Theory sessions can be completed online with any institution and a certificate produced for verification.
- Practical sessions must be completed by a qualified person who is certified as a 'manual handling' assessor, usually physiotherapists or occupational therapists.

It is the responsibility of the provider to ensure and maintain records of the trainer's qualifications:

- Cert IV Training and Assessment
- Current qualifications to assess First Aid, BLS or Manual Handling.

4.6.2 Medication management competency

Where applicable, personnel administering or assisting with medications must maintain the relevant medication management (administration or assistance) competency.

Community Nursing provider policies and guidelines should align with the Department of Health and Aged Care (DHAC) [Guiding Principles for Medication Management in the Community](#) and [National Medicines Policy](#). In addition, [Achieving continuity in medication management – Guiding Principles](#) and [Glossary for the Guiding Principles and User Guide](#) should be referred to as needed.

4.6.3 Infection prevention and control training

Providers are responsible for ensuring all personnel are trained in infection prevention and control and can determine which course should be completed. Further information and recommended courses on COVID-19 and infection prevention and control can be found at:

- [Department of Health and Aged Care – COVID-19 resources and training](#)
- Australian Commission on Safety and Quality in Health Care:
 - [Infection prevention and control for aged care eLearning modules](#)
 - [Infection prevention and control – advanced education eLearning modules](#).

4.6.4 Continuing education and performance management for personnel

The Community Nursing provider must ensure its personnel have access to, and undertake, appropriate continuing education and professional development, particularly in relation to the provision of community nursing services, on a regular and ongoing basis.

The Community Nursing provider must have a training system in place that ensures personnel maintain the necessary skills and competencies to effectively perform their role, and applicable training is documented in personnel records. Providers must also have processes in place to ensure personnel performance is regularly assessed and reviewed, with outcomes recorded as appropriate in personnel records.

The Community Nursing 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 online at www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx.

Personnel should be kept informed and maintain awareness of all current applicable organisational policies and procedures.

5 Assessment and care documentation

Care documentation, including clinical progress notes, assessment documentation and care plans, must remain up-to-date and be based on contemporary community nursing industry best practice standards.

5.1 COMPREHENSIVE ASSESSMENT

An RN must assess the nursing care need/s of a client through a comprehensive clinical assessment. Assessments must occur face-to-face in the client's home and be undertaken:

- upon receiving a referral from an authorised referral source
- following transfer from another Community Nursing provider
- on the 12 month anniversary from the commencement of care (where there have been 13 consecutive 28-day claim periods).

A comprehensive clinical assessment includes the use of validated assessment tools based on current community nursing industry best practice standards. Assessment tools required will be based on the identified care needs of the client, for example:

- skin assessment
- continence assessment
- falls risk assessment tool (FRAT)
- sleep assessment
- nutritional assessment.

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

For community nursing services to be provided to a client, there must be an assessed clinical need for nursing care. Where an assessment is undertaken and there are no services provided and no ongoing care needs are identified, the Community Nursing 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.

The assessment should also identify any allied health or community services that are required, for example wound care specialist, occupational therapy, credentialed diabetes educators, delivered meals etc., and a request made to the

GP to arrange referrals as appropriate. See [Section 12 – Interaction with other health and community support service providers](#).

The outcome of any assessment should be clearly communicated to the client, and to their carer if appropriate.

5.1.1 Assessment of personal care needs

When a client is assessed as requiring low level personal care services and the client does not have a clinical need for any other community nursing services, the personal care services should be provided through the Veterans' Home Care (VHC) Program. The Community Nursing 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 personal care services as well as having a clinical need for community nursing services, all of the required personal care services should be provided through the Community Nursing Program where possible.

5.2 CARE DOCUMENTATION

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

A client's care documentation must be developed in conjunction with the client and, if applicable, their authorised representative. The client must be provided with, or be able to access in a timely manner, a copy of their current care documentation. The client, or their authorised representative, 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.

5.2.1 Nursing care plan

Care documentation must include a nursing care plan that is developed, completed and signed by an RN following the comprehensive assessment.

Care plans must be developed with, and tailored to the client, factoring in the client's needs, goals and preferences, reviewed regularly and updated, including when:

- the client's needs, goals or preferences change
- the client's ability, mental health, cognitive or physical function, capacity or condition deteriorates or changes
- the care that can be provided by a client's carer changes

- risks emerge or change or there is an incident that impacts the client
- all or part of the client's care is transferred between others involved in the client's care.

A nursing care plan must include:

- clinical and personal care interventions to meet identified care needs
- client's level of / capacity for independence
- client's goal/s of care and agreed actions (short and long term), including their cultural needs
- desired outcome/s of care
- delegation of care within scope of practice as per [Section 4.2.1 – Delegation of care](#)
- review dates
- agreed days and approximate timeframes that services will be delivered
- supports for the client's wellbeing and quality of life, maximising the client's independence and supporting their reablement
- information about the risks associated with care and service delivery and how staff can support clients to manage these risks.

Where an assessment through My Aged Care (DHAC) has not been conducted for clients over 65 years of age, the Community Nursing provider should facilitate one within the first 28-day claim period for eligible clients.

Care plans must be accessible by the client. All personnel must ensure the current care plan is referenced in delivery of services to the correct client.

5.2.2 Clinical progress notes

Care documentation must include contemporaneous progress notes of all clinical and personal care provided to the client during each visit. Progress notes must be:

- current, contain relevant and up-to-date information that accurately reflects the event/s being documented
- clear and concise i.e. as specific as possible
- able to inform a handover of care from one visit to the next
- readily available and accessible to all those involved in the client's care
- legible and can be understood, with the use of acronyms and abbreviations avoided.

6 Community Nursing Fees Classification

A Community Nursing provider must appropriately classify a client under the Classification System, as set out in the [Community Nursing Schedule of Fees](#), based on the care and services provided.

The Classification System, referred to as the Schedule of Fees throughout the Notes, is based on:

- an episode of care model where a provider retrospectively claims for payment at the end of each 28-day claim period
- groupings of visit types in separate schedules:
 - Clinical Care (core, add-on, second worker and overnight)
 - Personal Care (core, add-on, second worker, and overnight)
 - Other Items.

[Table 1](#) demonstrates some examples of core, opposing add-on schedule and other items.

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.

6.1 MAJORITY OF CARE PRINCIPLE

A Community Nursing 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 the length of visit time may represent the majority of care.

Where time and the number of visits have been equally spent on clinical and personal care, the client should be classified under the Clinical Care schedule.

6.2 COMBINATIONS OF CARE

The Schedule of Fees allows for combinations of care, for example:

- if the majority of care is from the Clinical Care core schedule, a Personal Care schedule add-on can also be claimed if personal care is delivered; or
- if the majority of care is from the Personal Care core schedule, a Clinical Care schedule add-on can also be claimed if clinical care is delivered.

If any other community nursing services or nursing consumables are also provided, item numbers from the Other Items and/or Nursing Consumables schedule may also be claimed.

6.3 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 Community Nursing provider should be under the supervision of the relevant specialist palliative care team, where clinically required.

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 core schedule. They are:

- Clinical Support (short term)
- Clinical (Short or Long)
- Post-Operative Eye Drops.

6.3.1 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 for a short term period. These could include coordination, health education and goal setting, or monitoring, and be based on an identified clinical need that is definable and has expected health outcomes.

The Clinical Support classification is short term 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
- 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, Community Nursing 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 Community Nursing provider, Clinical Support cannot be claimed while the client remains enrolled in the CVC Program.

6.3.2 Clinical (Short or Long)

There are two visit lengths in the Clinical Care visit type. A client can be classified as:

- Clinical Short (20 minutes or less) with visit range items, or
- Clinical Long (21 minutes or more) with 11 visit range items.

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

6.3.2.1 Mix of short and long visits

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

6.3.2.2 Medication administration

The client must be classified under the Clinical Care schedule and the care must be provided by an RN or EN (who has completed the required education and does not have a notation on their registration) if the client requires the administration of medications.

Where a client requires medication administration or assistance with medication, the care interventions are to be documented in the medication management section of the nursing care plan. A medication authority or signed medication chart must be provided by the prescribing/referring medical practitioner or an authorised prescriber and must include the medication name, dosage, and administration times. Medication charts must include the name, role identity and initials of the personnel administering or assisting with the medication. All medication documentation must be legible.

RNs and ENs (without notation) can administer medication only when an authorised prescriber has prescribed the medication.

Australian state or territory legislation and guidelines, together with provider organisational policies, define some medicines as potential 'nurse-initiated' medicines. These medications (which includes some Schedule 2 and 3 medicines) can be administered by an RN without authorisation by an authorised prescriber.

Further information on medication guidelines is available under [Section 4.5.2 - Medication management competency](#).

6.3.2.3 Symptom management

When a client is referred to the Community Nursing Program for symptom management for an unstable disease/condition, those visits must be classified under the Clinical Care visit type in the Schedule of Fees, not Clinical Support.

Symptom management requires a GP/specialist medical practitioner to provide a diagnosis, orders regarding a treatment plan, and medication orders.

6.3.3 Post-Operative Eye Drops

This visit type is specifically for eye drop administration, prescribed by a specialist medical practitioner, 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
- is based on a minimum of more than 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 under the Clinical or Personal Care schedule, 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.

6.4 PERSONAL CARE SCHEDULE

A Community Nursing provider will classify a client into the Personal Care visit type when personal care is the core care requirement for community nursing services.

The goal of personal care is to support the clinical outcomes of a client so that they can remain independently at home for 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 and toileting
- dressing
- assistance to eat (which may include heating a meal)
 - assistance to eat may be provided, however this must meet a clinical need and a nutritional assessment is required to identify nutritional risk
- mobility / transfer (walk with assistance / move from one position to another manually, or with aids / equipment e.g. mechanical lifter).

If the client'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.

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 under the Personal Care schedule include RNs, ENs and PCWs. Personal care services delivered by an RN or EN cannot be claimed under the Clinical Care schedule. The Community Nursing provider must ensure that all community nursing 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 4.2.1 - 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 where the number of visits is over 35. The visit lengths are:

- Short – up to 30 minutes per visit
- Medium – 31 to 45 minutes per visit
- Long – 46 minutes or more per visit.

6.4.1 Remote Delivery of Clinical Wellbeing Checks

The provision of Remote Delivery of Clinical Wellbeing Checks has been extended until 30 June 2025.

DVA recognises monitoring clients' clinical wellbeing occurs naturally through regular face-to-face services. Where face-to-face visits cannot occur, including as a result of workforce shortages or extreme weather events, this monitoring should continue, where clinically appropriate. Remote wellbeing checks should be recorded in the client's file, including the reason a face-to-face visit could not

be conducted. Where Community Nursing providers deliver clinical wellbeing checks remotely, this can be claimed through the Schedule of Fees under the Personal Care classification.

6.4.2 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 Community Nursing 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 item (short, medium or long) that can be claimed.

6.4.3 Assistance with medication

PCWs may only assist or support a client to self-administer their own medication/s. Assistance with medication may include prompting to take medications, opening a dose administration aid (DAA) or assisting with a medicine container (e.g. unscrewing bottle lids or removing medicines from a container and placing in the client's hand).

A PCW can only assist or support a client with self-administered medication when the following criteria are met:

- the client's medical condition/s is/are stable
- the client is responsible for managing their own medication
- there is a medication authority or medication chart for all medications (including any over the counter/non-prescription medicines that are not in a DAA signed by the prescribing medical practitioner)
- there is a nursing care plan in place which includes medication contraindications (interactions and side-effects) and emergency contacts
- there is a blister pack filled by a registered Pharmacist which meets the DVA [DAA service](#) requirements and/or the medication is dispensed by a pharmacist into an individual container or pack, and is labelled with the:
 - person's name
 - name and strength of the medicine
 - dosage, frequency and route of administration
- the PCW:
 - has completed a suitable competency/vocational training course in 'assistance with medication administration' via a [registered training organisation](#) (RTO), registered with the [Australian Skills Quality Authority \(ASQA\)](#). E.g., Certificate III in Individual Support, or its equivalent, which includes a unit of competency that prepares PCWs to physically assist people with their medicines.
 - adheres to the relevant Commonwealth and State/Territory Drugs and Poisons Acts (however titled)

- adheres to the Community Nursing provider's medication assistance policy/ies and procedures
- is working under the delegation of an RN (see [Section 4.2.1 – Delegation of care](#)), and any change in health status is reported immediately to the RN
- provides assistance that is consistent with their level of training and competence
- the RN (or an EN without notation) 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 – Seven day review](#)
- the provider conducts annual medication competencies for the relevant PCWs and keeps individual PCW records for auditing and safety requirements
- the provider aligns their policies and procedures with Department of Health and Aged Care policies and related guidelines. See [Section 4.5.2 – Medication management competency](#) for further information.

PCWs are not authorised to make any decisions about whether a medicine should be administered and need to seek assistance from an RN if they have any concerns about a person's management of their medicines.

If the above criteria cannot be met by a PCW, the care must be provided by an RN or EN (without notation) and classified under the Clinical Care schedule, see [Section 6.3.2.2 – Medication Administration](#) for more information.

The Community Nursing provider must ensure that the assistance with self-administration of medication by an EN and/or PCW is planned, appropriately delegated, supervised and documented by an RN, see [Section 4.2.1 – Delegation of care](#).

The Community Nursing 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.

6.5 OTHER ITEMS AND ADD-ONS SCHEDULES

The Schedule of Fees includes Other Items and Add-ons which provide additional item options for the provision of community nursing services.

Most Other Items and Add-ons can be claimed in conjunction with a Clinical or Personal Care core item number when the services are provided in the 28-day claim period.

The Other Items and Add-ons 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](#))
- Exceptional Case (see [Attachment A – Exceptional Case process](#))
- Coordinated Veterans' Care (CVC) Program items (see [Attachment E – Community Nursing and the Coordinated Veterans' Care Program](#)).

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.

6.5.1 Assessment

This visit type is used to claim the initial comprehensive assessment undertaken by an RN for every client, and at each 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 Community Nursing 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 the Community Nursing Program and re-admitted on more than one occasion, prior approval from DVA will be required to claim a fourth (or more) assessment item.

6.5.1.1 Assessment – ongoing community nursing services required

The Assessment item (NA02) for ongoing services can be claimed following the completion of a comprehensive assessment.

This item can be claimed in conjunction with:

- core and add-on item numbers from the Clinical Care and/or Personal Care schedules
- 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 schedule within an existing 12 month period of care).

The Community Nursing provider must communicate the outcomes from each comprehensive assessment to the client's GP.

6.5.1.2 Assessment only – no ongoing community nursing services required

Assessment item (NA99), where no ongoing community nursing services are required, can be claimed only once per client within three consecutive 28-day claim periods (84 days).

The Community Nursing 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 or community support services, if these are required.

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

6.5.2 Palliative care

Palliative care Add-ons can be 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 medication administration, will be claimed under a Clinical Care visit type. If a client diagnosed with a life-limiting illness requires only personal care services, this will 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
- neurodegenerative disorders such as Huntington's Disease or Motor Neurone Disease.

Palliative care services, including clinical interventions, should be coordinated and provided in conjunction with the specialist palliative care team, including the treating specialist medical practitioner, the client's GP and any other health providers involved in the client's care.

Personnel used to deliver palliative care services can include RNs, ENs or PCWs, based on their qualifications and experience and the client's nursing care requirements.

6.5.2.1 Palliative care phases

There are five Palliative Care and Other Items which encompass the palliative care phases of:

- stable
- unstable
- deteriorating
- terminal
- bereavement.

For further details see [Attachment C - Palliative Care Phases](#).

6.5.2.2 Mix of palliative care phases

A client may move between two or more palliative care phases during a 28-day claim period.

Where this occurs, the Community Nursing provider should claim the palliative care phase item that reflects the majority of the phase the client was in during the 28-day claim period.

6.5.2.3 Palliative care – claiming

The four palliative care item numbers can be claimed with the following:

- a Clinical Care schedule item number (core, add-on, or overnight care item, excluding Post-Operative Eye Drops)
- a Personal Care schedule item number (when there is an add-on from the opposing Clinical Care schedule).

A Community Nursing provider can only claim one palliative care item number for a client in a 28-day claim period.

The Palliative Stable item 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 to also be claimed.

The Palliative Terminal item number:

- can only be claimed once for a client
- can only be claimed after the death of a client, using the start date of the final claim period in which services were delivered
- cannot be claimed with any other Palliative Care Items.

6.5.3 Bereavement follow up

The Bereavement follow up item is used for visit/s to a bereaved family member or carer following the death of a client who recently received community nursing services. The client must have been receiving community nursing services from the Community Nursing 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 and must 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.

6.5.3.1 Bereavement follow up – claiming

Bereavement follow up can only be claimed once, following the death of a client. The claim date for this item number must be the same start date as the final claim period for payment regardless of when the bereavement visit/s actually occur.

6.6 SECOND WORKER

A second worker may be required to assist the primary worker for some, or all, of the scheduled visits for community nursing services.

For example, a second care worker could be utilised where a client requires two workers to assist them to mobilise to the shower and/or for transfers. In this scenario, a second worker personal care item may be claimed for the delivery of services.

The requirement for a second worker to provide services to a client during the same visit for the same task must be documented in the nursing care plan. A clinical care second worker item can only be claimed with a clinical care core item, and a personal care second worker item can only be claimed with a personal care core item.

To claim for the provision of second worker services, an item from the second worker item range can be claimed from the Schedule of Fees.

6.7 OVERNIGHT CARE

A Community Nursing provider may provide overnight nursing care for a client where there is an assessed clinical or personal care need. Overnight care is considered a short-term provision. If extended periods of overnight care are required, regardless of whether clinical or personal, an Exceptional Case application should be submitted.

Criteria for the provision of overnight nursing care

Overnight nursing care can be provided where the following criteria are met:

- ✓ to provide clinically required nursing care/tasks that arise overnight while the client is sleeping, from bed time to waking
- ✓ the overnight nursing tasks are:
 - assessed by an RN as clinically required
 - documented in the client's care plan
 - within scope of the Community Nursing Program
- ✓ must be for a minimum of 6 hours to support the client overnight when the client is sleeping (e.g. 10.30 pm – 6.30 am, **not** 7.00 pm – 11.00 pm)
- ✗ **Overnight care cannot be for the sole purpose of providing respite or supervision, or to replace or establish the role of a carer or undertake non-nursing tasks (e.g. IADLs).**

6.7.1 Types of overnight care

6.7.1.1 Overnight clinical care

Overnight clinical care is generally provided as a short-term measure only, for example, if clinical care is required after a client has been discharged from hospital or if the client is in the terminal/end of life phase and requiring pain and symptom management. Overnight clinical care can only be claimed when the client has been assessed by an RN as requiring clinical care overnight.

A client may require overnight clinical care when an RN or EN is required to perform nursing tasks during the night. For example:

- administration of medications that cannot be prompted/assisted by a PCW
- management of complex tracheostomy and/or wound care needs
- pain and symptom management for terminal phase/end of life care
- complex care where the client has multiple comorbidities and/or other complexities.

Where long term overnight clinical care is required, an Exceptional Case application should be submitted.

6.7.1.2 Overnight personal care

Overnight personal care can be provided by an RN, EN or PCW. A client may require personal care overnight for reasons including:

- toileting and/or mobility assistance
- medication prompting/assistance
- pressure area care (where mattresses and/or other pressure area devices are not sufficient for long periods)
- active intervention strategies where the client is agitated, confused or disoriented and/or presents with challenging behaviours (for example due to end stage dementia or other life limiting illnesses).

When the client has been assessed by an RN as requiring personal overnight care, clinical care cannot be claimed, regardless of the personnel providing the care. That is, if only an RN is available to provide overnight care classified as personal care, this cannot be claimed as clinical overnight care.

6.7.1.3 Active overnight care

Active overnight care involves the provision of continuous active care throughout the night or where the client requires assistance three times or more and the active care is greater than 2 hours in total. The personnel (RN, EN or PCW) delivering care do not have a sleep time and are awake to provide assistance as required throughout the duration of the overnight care visit.

Active overnight care should generally correlate with clients who have patterns of exceptional clinical needs and/or challenging behaviours throughout the night. Examples include:

- restlessness, insomnia or confusion (e.g. where a client has vascular dementia or end stage dementia)
- multiple episodes of bowel movements (despite review by a GP and/or continence nurse and strategies remain unsuccessful)
- administration of medication
- maintaining essential nutrition and hydration.

If a client experiences incontinence and/or is considered a high risk for pressure injuries, an RN must complete a relevant incontinence, toileting and/or skin assessment and document the findings in the client's care plan.

6.7.1.4 Inactive overnight care

Inactive overnight care occurs where personnel are required to provide assistance to the client up to two times, for up to one hour each time. The personnel delivering care can sleep when not required to provide care. If the personnel are required to provide assistance three or more times during the night, providing more than 2 hours of care, the visit may be claimed as active overnight care.

Where a client requires continence aids, in order to minimise unnecessary sleep disturbance for the client, the correct size/fit and capacity should be used for the duration of the night. In some cases, one continence aid change may be required.

Clients with a high risk of pressure injury should have appropriate pressure relieving aids implemented by an RN or an Occupational Therapist. Client care goals should be considered to balance any sleep disruption, as outcomes are not improved by regularly interrupting sleep, including to turn, reposition, or massage the client.

6.7.2 Overnight care guidelines

Overnight care can be provided for clinically required nursing care/tasks that arise overnight while the client is sleeping, from bed time to waking.

- Overnight nursing tasks must be:
 - assessed by an RN as clinically required
 - documented in the client's care plan
 - within scope of the Community Nursing Program
- Overnight care must be for a minimum of 6 hours to support the client overnight when the client is sleeping (e.g. 10.30 pm – 6.30 am, **not** 7.00 pm – 11.00 pm)

- Overnight care may commence up to 60 minutes prior to the client's usual bed time where other care, for example medications, showering and catheter bag changes are required
- Overnight care may end up to 60 minutes after the client's usual waking time to provide other care, for example medications, showering, catheter bag changes
- Where the overnight care is extended to include these tasks, a separate visit of the same type (clinical or personal care) should not occur within 2 hours of the overnight care visit, unless there is an identified clinical care need
- E.g.: if 10 hours of overnight care is provided, this would indicate the client is sleeping for approximately no less than 8 hours, and requires assistance prior to bed time and assistance with cares on waking.

*** Overnight care cannot be for the sole purpose of providing respite or supervision, or to replace or establish the role of a carer or undertake non-nursing tasks (e.g. IADLs).**

6.7.3 Overnight care assessment

All clients must have an assessment conducted by an RN to determine if overnight care is required, with clinical requirements documented in the client's care plan. The type of overnight care (personal or clinical, active or inactive), must be determined prior to the commencement of services, including the personnel type required to deliver services.

A sleep chart (or similar assessment tool) should be conducted for a minimum of 3 days/nights to establish the client's sleep and wake times (including any sleep periods during the day) and assist the RN in their assessment of overnight care provisions, and can be completed by any personnel type, carer or family member. The sleep chart will support the RN in identifying the specific overnight care needs and tasks. The RN must review the sleep chart/assessment and document the relevant information (e.g. sleep and wake times and care needs) in the client's care plan.

Overnight care cannot be provided solely on the basis of a request from a client, GP or family member. The requirement for overnight care is based on the client's clinical care needs and determined by the RN assessment.

The ongoing requirement for overnight care must be reassessed on a regular basis to confirm that the care is clinically necessary (refer to [Section 8 – Review of care](#)) and the reasons for ongoing care documented in the client's care plan.

6.7.4 Overnight care claiming

- Overnight nursing care is classified as clinical or personal, and active or inactive.

- Overnight care is claimed for each night care was provided and can be claimed up to a maximum of 28 nights per claim period where clinically required.
- Overnight nursing care should be claimed in the same 28-day claim period as other required services provided to the client.
- The care type must remain consistent and not alternate between clinical and personal care unless there is a change to the client's care requirements. Where the care needs change, the client must be reassessed by an RN and the change in care requirements documented in the client's care plan.
- The overnight care type must be determined by the assessed needs of the client and not based on the availability of staff. For example, if the assessed need is personal care, clinical care cannot be claimed regardless of the personnel that provides the care i.e. if an RN or EN provides personal care overnight, clinical care overnight cannot be claimed.
- Where the overnight nursing care required cannot be provided under the Schedule of Fees, an Exceptional Case application should be submitted.

6.8 NURSING CONSUMABLES

Nursing Consumables items can be claimed by Community Nursing providers for reimbursement for products used, excluding items contained in 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 Community Nursing provider should claim the 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 Community Nursing provider *must not* include any nurse's toolbox items or GST component when calculating which Nursing Consumable item number to claim. Payments made to Community Nursing providers automatically add the GST component prior to payment.

There is an upper reimbursement limit of \$1,500 (excluding GST) 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](#).

Table 1: Core Schedule and additional items

Schedule	Core Item	Add-Ons (Opposing Schedule)	Other Items (Assessment)	Other Items	Other Items (Palliative Care)	Other Items	Other Items (CVC)	Second Worker	Overnight Care	Nursing Consumables
Personal Care	CORE Personal Care item number	ADD-ON from opposing Schedule for Clinical Care Core	Assessment (NA02)	Bereavement Follow-up (NA03)	Palliative (Stable, Unstable, Deteriorating, Terminal) (NA04-NA07)	Additional Travel (NA10)	CVC (UP05 and UP06)	Second Worker Personal Care	Overnight Care	Nursing Consumables (NC10 – NC70)
Clinical Care	CORE Clinical Care item number	ADD-ON from opposing Schedule for Personal Care Core	Assessment (NA02)	Bereavement Follow-up (NA03)	Palliative (Stable, Unstable, Deteriorating, Terminal) (NA04-NA07)	Additional Travel (NA10)	CVC (UP05 and UP06) (NOT where NL01 or NL02 have been claimed)	Second Worker Clinical Care	Overnight Care	Nursing Consumables (NC10 – NC70)
EC Approval	Approved EC item number	N/A	Assessment (NA02 – only first 28-day claim period)	Bereavement Follow-up (NA03)	N/A	Additional Travel (NA10)	N/A	N/A	N/A	Nursing Consumables (NC10 – NC70)

7 Claiming

A Community Nursing provider claims for payment for the delivery of community nursing services to a client through Services Australia (Medicare).

DVA recommends Community Nursing providers use Medicare's [online claiming](#) services as they provide a number of efficiencies and cost-savings for health care providers.

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

A DVA client must never be asked to make a payment for the delivery of community nursing services by a Community Nursing provider.

7.1 28-DAY CLAIM PERIOD

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

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

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

- according to the core community nursing service provided (based on the majority of care principle), and/or
- if required, utilise an Add-on item from the opposing schedule (based either on lesser visit count or lesser time, whichever is applicable), and/or
- if required, include any Other Items from the schedule (based on additional services or nursing consumables provided).

7.1.2 Two providers in a 28-day claim period

Where a client requires services from two Community Nursing 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 is expected the providers will liaise with each other to ensure there is no duplication, and that the client's full clinical needs are met.

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.

A client may require services from two providers when one provider is not able to provide all the required care, and a second provider is required to meet a client's clinical and personal care needs.

However, some services can only be claimed once in a 28-day claim period per client and Community Nursing providers should ensure these services have not already been delivered by another provider. These are:

- Assessment only – no other services required
- Exceptional Case
- Coordinated Veterans' Care (CVC) Program items.

7.2 MINIMUM DATA SET

DVA requires Community Nursing 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 collects information on:

- Claim details:
 - client's name, file number and claim period start date
 - item numbers claimed.
- Staffing resources used in the 28-day day claim period:
 - the personnel delivering community nursing services to the client
 - visits 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 Community Nursing provider must complete the MDS for every 28-day claim period that it delivers community nursing services to a client. Community Nursing providers who use online claiming to submit their claims automatically submit the MDS as part of their claim submission.

7.2.1 Why DVA requires 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 and improvements.

7.2.2 Items that require MDS

All item numbers except Nursing Consumables (NC10 – NC70), Additional Travel (NA10) and CVC Program items (UP05 & UP06) require MDS.

7.2.3 Recording MDS when an RN/EN provides both clinical and personal care

In instances where an RN/EN delivers clinical and personal care in the same visit and a Community Nursing 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. It is possible that one visit may involve 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:

- personal care (core item)
- clinical care (opposing schedule add-on) and
- palliative care (Other Items add-on).

7.2.4 Submitting MDS data

MDS data is submitted at the end of each 28-day claim period either:

- as part of a Medicare claim made online via electronic claiming software to Services Australia (Medicare) or
- manually by secure email to DVA, using the MDS Collection Tool.

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

7.2.4.1 Online

Community Nursing providers are able to lodge claims for payment and submit MDS through Medicare's [online claiming](#). This is the preferred method for claiming and submitting MDS. Community Nursing providers who use online claiming to submit their claims automatically submit the MDS as part of their claim submission.

7.2.4.2 Manual

Community Nursing providers who claim for services manually (i.e. by post) must submit their MDS each claim period by using the MDS Collection Tool. 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 Community Nursing provider for correction and resubmission.

For more information on the MDS Collection Tool process for manual claiming, refer to the MDS Collection Tool - Quick Reference Guide on the DVA website at [Information for DVA approved Community Nursing providers](#).

7.3 GOODS AND SERVICES TAX (GST)

The fees in the Schedule of Fees and for Exceptional Case status are exclusive of GST, as 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.

7.4 TIMEFRAME FOR CLAIMING

A claim for payment for community nursing 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.

7.5 SUBMITTING A CLAIM FOR PAYMENT

A Community Nursing 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 community nursing services provided to a client, the Community Nursing provider certifies that:

- the services were delivered by the Community Nursing provider or their subcontracted organisation
- the services were provided under an agreed nursing care plan for the client
- the services provided are within scope of the Community Nursing Program as outlined in the Notes
- the claim is a true representation of the community nursing services provided.

7.6 CANCELLED VISITS

Where a scheduled visit is cancelled at short notice by the client, or the Community Nursing provider personnel arrives for a visit and the client is not home, the services that would otherwise have been provided 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.

7.7 RETENTION OF CLAIMS

Community Nursing providers must retain their claims in a storage system which is able to be accessed for review purposes.

A Community Nursing provider must be compliant with the Australian Privacy Principles, see [Section 10.3 - Privacy, documentation and record keeping](#).

7.8 PAYMENT METHOD

Community Nursing providers are paid directly by Medicare into a nominated bank account. A Community Nursing provider should contact Medicare on 1800 700 199 to provide these details. For information about the payment method, or to access online claiming information and forms, visit [Services Australia - Banking details online claim form \(HW052\)](#).

7.9 QUERIES ABOUT CLAIMS

If a Community Nursing provider has any queries about the status of a claim/s for payment they should contact Medicare on 1300 550 017 (select option 2).

7.10 UNSUCCESSFUL CLAIM/S FOR PAYMENT

A claim for payment may be unsuccessful in full or in part. Medicare will inform the Community Nursing 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 Community Nursing provider.

7.11 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.

7.12 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 community nursing services delivered to a client with Exceptional Case status. For further details, see [Attachment A - Exceptional Cases – Exceptional Case Variation Form](#).

7.13 INCORRECT PAYMENT/S

An incorrect payment may involve either an overpayment or an underpayment. An incorrect payment may be identified by DVA or the Community Nursing provider. If an incorrect payment is identified by DVA, Medicare will contact the Community Nursing provider and manage the adjustment process.

If a Community Nursing provider identifies an incorrect payment, they 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 Community Nursing provider. The RCAN replaces the RCTI previously provided with the incorrect payment.

7.14 INAPPROPRIATE CLAIMING

DVA has systems in place to monitor and report on the servicing and claiming patterns of services provided under the Community Nursing Program. These systems are aimed at detecting and preventing fraud and non-compliance, and include post payment monitoring, which may be conducted as a stand-alone activity or as part of a Quality and Safety audit.

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, are 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 their clinical or personal care needs. DVA is committed to providing clients with quality and appropriate health care services through the Community Nursing Program.

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
- 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* (PGPA Act) and the *National Anti-Corruption Commission Act 2022* (NACC Act). Failure to meet obligations to conduct business with the Commonwealth in an honest manner may result in provider education, recovery of monies or prosecution.

Community Nursing providers must implement and maintain fraud prevention controls and be able to demonstrate these controls to DVA on request.

7.15 RECOVERY OF OVERPAYMENTS

DVA will advise Medicare of any overpayments, and they will initiate a process to recover any overpayments that are 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.

Medicare will write to the provider to explain the overpayment and ask them to issue a refund within 30 days.

8 Review of care

The Community Nursing provider must conduct a review of the care needs of a client at required times throughout the client's episode of care noted below, depending on the type of care the client receives. Each review *must* be recorded in the client's care 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 under 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 without notation) every seven days.

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

8.2 28 DAY REVIEW

The Community Nursing provider will review the care provided to a client at the end of the 28-day claim period:

- if the client is classified under the Clinical Care schedule (either as a core, add-on, or clinical overnight care), the review at the end of each 28-day claim period *must* be conducted by an RN
- if the client is classified under the Personal Care schedule (with no clinical care add-on or clinical overnight care), the review at the end of each 28-day claim period *must* be conducted by either an RN or an EN.

The purpose is to review the nursing care plan and clinical 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)
- other care and service/s provided from the schedule (if required).

8.2.1 Temporary changes to 28 day reviews

Community Nursing providers are able to claim for remote delivery of 28 day reviews, initially introduced as a temporary measure in April 2020. For the period until 30 June 2025, Community Nursing providers may conduct the 28 day review by telehealth, where clinically appropriate, to alleviate the need for an RN or EN to travel to a client's house if the sole purpose of the visit is to conduct this review. The client's progress notes / file should be updated following the review.

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 community nursing services being delivered. A file note *must* be entered into the client’s care documentation when the review is completed. All delegated care details must be appropriately documented in clinical records and kept in the client’s file.

In undertaking the review, the RN will identify any changes required to the community nursing services, and document and implement those changes in consultation with the client or their nominated representative.

If the review identifies a change to services is required, the Community Nursing provider must notify the client’s GP where relevant and either:

- reclassify the client within the Schedule of Fees if there is a change to the majority of care, or
- identify the need for the client to be assessed through the Exceptional Case process, or
- discharge the client from community nursing services.

For a client classified as Palliative Stable and the community, the RN will identify whether claiming this item continues to be appropriate.

If there is no clinical need for community nursing services and the client requires non-clinically necessary personal care services, the Community Nursing provider should discharge the client and refer them to VHC for an assessment for personal care services, see [Section 5.1.1 – Assessment of Personal Care Needs](#) and [Section 12.1 – Veterans’ Home Care \(VHC\) Program](#).

8.4 REVIEW OF CARE SUMMARY

Time Period	Activities	Personnel Level
Seven days for Personal Care where a PCW provides assistance with self-administration of Schedule 8 drugs	Review medication management and ensure the delegations are still appropriate. A clinical care add-on may be claimed for this review.	RN; or EN (without notation)
Seven days for clients with Exceptional Case (EC) status	Review all clinical and personal care needs There is <i>no</i> clinical care add-on that can be claimed. The review is included in the EC funding.	RN

28 days	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.	RN; or EN if only personal care is being delivered
Three monthly	Includes but not limited to: <ul style="list-style-type: none"> • 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 of classifications and that care delivered reflects the item number/s claimed. 	RN
At any time if care needs change	Review and update all assessment documentation and the nursing care plan to reflect 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 expects the client's GP to have ongoing clinical oversight and management of the client's care. As such, the Community Nursing provider must communicate with a client's GP on a regular basis, and record the communication in 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
- where a client and/or nominated representative decline services or issues arise preventing the delivery of services
- on discharge from community nursing services. When a client is discharged from community nursing 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 Community Nursing provider is required, on an ongoing basis, to identify:

- any significant change to clinical and/or personal care needs
- the need for an allied or other community health or support service and request a referral for service/s.

9 Discharge from community nursing services

A client must be discharged by a Community Nursing provider if the client:

- is absent from community nursing services for more than 28 days
- has been permanently admitted to a Residential Aged Care Facility
- transfers from the existing provider to another Community Nursing provider (with DVA approval if required)
- moves permanently to another location (not serviced by the current Community Nursing provider)
- no longer requires community nursing services.

The date of discharge from community nursing 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 GP should be notified verbally and in writing of the client's discharge, including if a client self-discharges, and any recommendations for other services or supports the client may require.

A discharge should not occur if the client is:

- absent from community nursing services for 28 days or less, for any purpose, e.g. for residential respite care, hospitalisation, holiday
- absent for short periods which do not interrupt planned community nursing services
- visited regularly, but infrequently, over a period longer than 28 days and which is considered one continuous delivery of community nursing services (e.g. for six – eight weekly indwelling or supra pubic catheter change).

9.1 ABSENCES FOR 28 DAYS OR LESS

Absences from community nursing 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 community nursing services for 28 days or less, and still requires community nursing services, they should recommence services with the same Community Nursing provider within the 28-day claim period to ensure continuity of care.

If the care needs have changed, the Community Nursing provider must update all assessment documentation and the nursing care plan. Fee item numbers must also be reviewed to ensure claiming accurately reflects the type and level of care being provided.

The client's GP must be notified of the outcome of the updated assessment.

9.2 READMISSION AFTER DISCHARGE

If community nursing services are required again after a client is discharged, regardless of the period of time since discharge, the Community Nursing provider must:

- obtain a new and valid referral prior to admission back into the Community Nursing Program
- conduct a new comprehensive assessment and develop a new nursing care plan.

10 Governance systems and policies

Community Nursing providers must ensure they have systems, policies and procedures in place to deliver safe and quality care to clients, in line with contractual arrangements and quality standards.

While not all Community Nursing providers are Aged Care providers, the Community Nursing Program aligns with the strengthened Aged Care Quality Standards.

10.1 PROVIDER GOVERNANCE SYSTEMS

Governance systems and processes support the delivery of safe, quality, effective and person-centred care to clients. The Community Nursing provider must lead a culture of safety, inclusion and quality that focuses on continuous improvement, embraces diversity and prioritises the safety, health and wellbeing of clients and the workforce.

Community Nursing providers must have governance systems, outlined below, in place to support the delivery of quality and safe care to clients and must be reviewed regularly for effectiveness and improvements implemented.

- Partnering with clients
 - Meaningful and active partnerships with clients inform provider priorities and continuous improvement.
- Quality and safety culture
 - The provider leads a culture of safety, inclusion and quality that focuses on continuous improvement, embraces diversity and prioritises the safety, health and wellbeing of clients and workforce.
- Accountability and quality
 - The provider is accountable for the delivery of quality care and services and maintains oversight of all aspects of their operations
 - The provider's quality system enables and drives continuous improvement of the care and services
 - Current policies and procedures guide the way workers undertake their roles.
- Risk management
 - The provider uses a risk management system to identify, manage and continuously review risks to clients, workers and the provider's operations
 - Collection and analysis of risk data feeds into the provider's quality system to improve care and services.
- Incident management
 - The provider uses an incident management system to safeguard clients and acknowledge, respond to, effectively manage and learn from incidents

- Collection and analysis of incident data feeds into the provider's quality system to improve care and services.
- Feedback and complaints management
 - Clients, workers and others are encouraged and supported to provide feedback and make complaints about care and services, without reprisal
 - Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services.
- Information management, including requirements under [Section 10.3 – Privacy, documentation and record keeping](#)
 - Information is identifiable, accurately recorded, current and able to be accessed and understood by those who need it
 - The information of clients is confidential and managed securely and appropriately, in line with client's informed consent
 - fraud prevention controls.
- Workforce planning
 - The provider understands and manages its workforce needs including engagement of suitably qualified and competent workers.
- Human resource management
 - The care and services needs of clients are met by workers who are skilled and competent in their role, hold relevant qualifications and who have relevant expertise to provide quality care and services
 - Workers are provided with training and supervision to effectively perform their role.
- Emergency management
 - Emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of clients and workers.

10.2 POLICIES AND PROCEDURES

A Community Nursing 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 are appropriate for a community nursing setting.

At a minimum, policies and procedures must include:

- Risk management
- Incident management
- Information management
- Emergency and disaster management
- Assessment and planning
- Infection Prevention and Control
- Medication management
- Client not responding
- Delegation of care

- Employee induction training.

Policies and procedures must be informed by contemporary, evidence-based practices, align with the strengthened aged care quality standards and contractual agreements, be accessible and understood by all personnel and reviewed at a minimum of every three years or in line with relevant legislation.

10.2.1 Quality Standard 1: The Person

A person-centred care approach including:

- workers understanding and valuing the client, including their identity, culture, ability, diversity, beliefs and life experiences
- care and services are developed with, and tailored to, the client, factoring in the client's needs, goals and preferences.

Provision of care and services with dignity, respect and privacy including:

- recognising, preventing and responding to violence, abuse, racism, neglect, exploitation and discrimination
- treating clients with dignity and respect
- the personal privacy of clients is respected.

Choice, independence and quality of life including clients being able to:

- exercise choice and make decisions about their care and services, with support when they want or need it
- receive timely, accurate, tailored and sufficient information, in a way they understand
- be supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life.

10.2.2 Quality Standard 2: The Organisation

Quality and safety including:

- focusses on continuous improvement, embracing diversity and prioritising the safety, health and wellbeing of clients and the workforce
- considers legislative requirements, operational risks, workforce needs and the care and services environment
- current policies and procedures that guide the way workers undertake their roles.

Risk management including how to:

- identify, assess, document, manage and regularly review risks to clients, workers and the Community Nursing provider
- prevent, control, minimise or eliminate identified risks.

Incident management including how to:

- record, investigate, respond to and manage incidents and near misses that occur in connection with the delivery of care and services
- reduce or prevent incidents from recurring, including the use of open disclosure.

Feedback and complaints including how to:

- receive, record and respond to complaints including the use of open disclosure.

Information management including:

- securely managing client information and records.

Workforce planning including:

- identify, record and monitor the number and mix of workers required and engaged to manage and deliver quality care and services.

Human resource management including:

- maintaining records of workers pre-employment checks, contact details, qualifications and experience
- training to ensure workers have the necessary skills, qualifications and competencies to effectively perform their role
- regular assessment, monitoring and review of workers performance.

Emergency and disaster management including:

- plans describing how the provider and workers will respond to an emergency or disaster and how to manage risks to the health, safety and wellbeing of clients and workers
- regular testing and reviews of the emergency and disaster plans/procedures with clients, family, carers and workers.

10.2.3 Quality Standard 3: The Care and Services

Assessment and planning including:

- identifying and recording the needs, goals and preferences of the client
- identifying risks to the client's health, safety and wellbeing and, with the client, identifying strategies for managing these risks
- supports preventative care and optimises quality of life, reablement and maintenance of function
- involves relevant health professionals where required for example, the client's GP
- directs the delivery of quality care and services
- being based on ongoing communication and partnership with the client and others that the client wishes to involve
- the outcomes of assessment and planning being effectively communicated to the client, in a way they understand and with the client's consent, to the client's family and others involved in their care
- care plans are individualised and:
 - describe the client's needs, goals and preferences
 - are current and reflect the outcomes of assessments
 - include information about the risks associated with care and service delivery and how workers can support clients to manage these risks
 - are offered to, and able to be accessed by, the client

- are used and understood by workers to guide the delivery of care and services
- care plans are regularly reviewed, including when:
 - the client's needs, goals or preferences change, or the care plan is not effective
 - the client's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes
 - the care that can be provided by a client's family or carer changes
 - transition occurs
 - risks emerge or there are changes or an incident that impacts the client
 - care responsibility changes between others involved in the client's care
- advanced care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care.

Delivery of care and services including:

- is culturally safe, trauma aware and healing informed including
 - provided in accordance with contemporary, evidence-based practices
 - meets the client's current needs, goals and preferences
 - referrals to the client's GP and other health professionals to optimise the client's quality of life, reablement and maintenance of function consistent with the client's preferences
- are appropriate for people with specific needs and diverse backgrounds including those identifying as Aboriginal and Torres Strait Islander, those living with dementia or have difficulty communicating
- is planned and coordinated, including where multiple providers, family and carers are involved in the delivery of care and services
- strategies for supporting workers to:
 - recognise risks or concerns related to a client's health, safety and wellbeing
 - identify deterioration or changes to a client's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition
 - respond to, and escalate, risks in a timely manner
- reasonable efforts to involve the client in selecting their workers (including the gender of, and language spoken by, workers providing care) and maximise worker continuity.

Communication for quality and safety:

- Critical information relevant to the client's care and services is communicated effectively with the client, between workers and with family, carers and health professionals involved in the client's care
- Risks, changes and deterioration in a client's condition are escalated and communicated as appropriate.

10.2.4 Quality Standard 4: The Environment

Risk assessments including:

- environment and equipment risks, to the safety of the client and/or worker, are identified and documented
- results of risk assessments are discussed with the client including options to mitigate the risks
- infection prevention and control including an appropriate infection prevention and control system which:
 - identifies an appropriately qualified and trained infection prevention and control nurse
 - prioritises the rights, safety, health and wellbeing of clients
 - complies with contemporary, evidence-based practice
 - describes standard and transmission-based precautions appropriate for the home setting, including cleaning practices, hand hygiene practices, respiratory hygiene, cough etiquette and waste management and disposal
 - ensures personal protective equipment is available to workers, clients and others who may need it
 - supports workers, clients and others who need to use personal protective equipment to correctly use personal protective equipment
 - includes additional precautions to respond promptly to novel viruses and outbreaks of infectious diseases (suspected or confirmed)
 - is informed by worker and client immunisation and infection rates
 - undertakes risk-based vaccine-preventable diseases screening and immunisation for clients and workers.

10.2.5 Quality Standard 5: Clinical Care

Clinical governance including the Community Nursing provider:

- implementing a clinical governance framework to drive safety and quality improvement
- implementing processes to ensure workers providing clinical care are qualified, competent and work within their defined scope of practice or role
- in conjunction with workers, agreeing on respective roles, responsibilities and protocols for providing quality clinical care
- working towards implementing a digital clinical information system that has processes for workers and others to access information in compliance with legislative requirements.

Preventing and controlling infections in clinical care including:

- clients, workers and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance
- the Community Nursing provider implementing processes to minimise and manage infection when providing clinical care that include but are not limited to:

- performing clean procedures and aseptic techniques
- using, managing and reviewing invasive devices including urinary catheters
- minimising the transmission of infections and complications from infections.

Safe and quality use of medicines including the Community Nursing provider:

- implementing a system for the safe and quality use of medicines, including processes to ensure:
 - access to medicines-related information for clients and workers
 - access for nurses and others caring for a client to the client's up-to-date medicines list and other supporting information at transitions of care
 - safe administration including assessing the client's swallowing ability, determining suitability of crushing medicines and providing alternative safe formulations when required
 - minimal interruptions to the administration of prescribed medicines including supporting access to medicines when a client is prescribed a new medicine or an urgent change to their medicine
 - documentation of a current, accurate and reliable record of all medicines and the clinical reasons for the treatment, including pro re nata (PRN) medicines
- having processes to ensure medication reviews are conducted including:
 - at the commencement of care, at transitions of care and annually when care is ongoing
 - when there is a change in diagnosis or deterioration in behaviour, cognition or mental or physical condition or when a person is acutely unwell
 - when there is polypharmacy and the potential to deprescribe
 - when a new medicine is commenced, or a change is made to an existing medicine or medication management plan
 - when there is an adverse event potentially related to medicines
- ensuring existing or known allergies or side effects to medicines, vaccines or other substances are documented at the commencement of care and monitored, with documentation updated when new allergies or side effects occur
- implementing processes to identify, monitor and mitigate risks to clients associated with the use of high-risk medicines, including referral to the GP regarding reducing the inappropriate use of psychotropic medicines
- processes to report adverse medicine and vaccine events to the Therapeutic Goods Administration
- regularly reviewing and improving the effectiveness of the system for the safe and quality use of medicines.

Comprehensive care including the Community Nursing provider:

- has an assessment and planning system that supports partnering with the client, family, carers and others to set goals of care and support decision making
- ensuring a registered nurse conducts a comprehensive clinical assessment on commencement of care, at regular intervals and when needs change, that includes:
 - identifying, documenting and planning for clinical risks, acute conditions and exacerbations of chronic conditions
 - identifying a client's level of clinical frailty and communication barriers and planning clinical care to optimise the client's quality of life, independence, reablement and maintenance of function
 - identifying and providing access to the equipment, aids, devices and products required by the client
 - referral to the client's GP when a change in the client's health or care needs change
- has processes to:
 - deliver coordinated and holistic comprehensive care in line with the care and services plan
 - communicate and collaborate with others involved in the client's care, in line with the client's needs and preferences
 - facilitate access to after-hours and urgent clinical care
 - provide timely notification to the client's GP, family, carers and health professionals involved in the client's care when clinical incidents or changes occur
- implements processes to monitor clinical conditions and reassess when there is a change in diagnosis or deterioration in behaviour, cognition, mental, physical or oral health, and at transitions of care.

Clinical safety including the Community Nursing provider has a system and processes that supports the identification, monitoring and management of high impact and high prevalence clinical risks, including but not limited to:

- Choking and swallowing:
 - to support safe chewing and swallowing when the older person is eating, drinking, taking oral medicines and during oral care
- Continence:
 - to optimise the client's dignity, comfort, function and mobility
 - ensure safe and responsive assistance with toileting
 - manage incontinence
 - protect the client's skin integrity and minimising incontinence associated dermatitis
- Falls and mobility:
 - to minimise falls and harm from falls including monitoring falls and injuries and reviewing the reasons for and consequences from falls
- Nutrition and hydration:
 - conducting regular malnutrition screening/observation

- referral to the client's GP when a risk of malnutrition or unplanned weight loss or gain is identified
- Mental health:
 - to optimise a client's mental health by responding supportively to signs of distress and symptoms of mental illness including self-harm and suicidal thoughts minimising risks to the psychological and physical safety of the client
 - referral to the client's GP when signs of deterioration of a client's mental health is observed
- Oral health:
 - incorporated in the initial comprehensive nursing assessment, regularly monitored and reviewed to prevent a decline in oral health, referring to the client's GP if deterioration is observed or suspected
- Pain:
 - regular assessment using an industry approved pain rating tool, including where the client experiences challenges in communicating their pain
 - planning for, monitoring, reviewing and responding to the client's need for pain relief including referral to the client's GP as required
- Pressure injury and wounds:
 - prevention of pressure injuries and management of pressure injuries by conducting routine comprehensive skin inspections, and monitoring and responding to pressure injuries and wounds when they occur
- Sensory impairment:
 - referral to the client's GP for assessment and management when changes are observed to a client's sensory functions including hearing, vision and balance disorders.

Cognitive impairment whether acute, chronic or transitory is identified and responded to by:

- identifying and mitigating clinical risks
- delivery of increased care requirements
- being alert to deterioration and underlying contributing factors
- collaborating with clients with cognitive impairment, their family, carers and others to understand the person and optimise clinical care outcomes
- implementing processes to identify and minimise situations that may precipitate changes in behaviour, and identify and respond to clinical and other identified causes of changes in behaviour including referral to the client's GP.

Palliative care and end-of-life care:

- The client's needs, goals and preferences for palliative care and end-of-life care are recognised and addressed and their dignity is preserved

- The client's pain and symptoms are actively managed with access to specialist palliative and end-of-life care when required, and their family and carers are informed and supported, including during the last days of life.

10.3 PRIVACY, DOCUMENTATION AND RECORD KEEPING

All Community Nursing 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
- assessments
- nursing care plans
- clinical progress notes
- dated reviews of care and the outcomes
- related care documentation
- claiming history.

Community Nursing providers must ensure the storage and security of personal information regarding a client is in accordance with relevant State or Territory and Commonwealth privacy laws, including the *Privacy Act 1988* (Cth) and the Australian Privacy Principles (APPs) (under Schedule 1 of the Privacy Act).

Information about privacy, the Privacy Act and the APPs can be accessed through the Office of the Australian Information Commissioner (OAIC) website at www.oaic.gov.au/privacy.

The OAIC's "Guide to securing personal information" provides guidance on information security, specifically the reasonable steps entities are required to take under the Privacy Act to protect the personal information they hold: www.oaic.gov.au - Guide to securing personal information. Community Nursing 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.

The Community Nursing 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. Community Nursing 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

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

To facilitate Quality Assurance activities or Performance Monitoring processes, DVA may request copies of the care, administrative, and/or claiming documentation. DVA will collect, use, access, disclose and store the documentation it receives in accordance with relevant Commonwealth laws, including the Privacy Act, the *Freedom of Information Act 1982*, the *Veterans' Entitlements Act 1986*, the *Safety Rehabilitation and Compensation (Defence-related Claims) Act 1988*, and the *Military Rehabilitation and Compensation Act 2004*.

10.5 REFUSAL OF SERVICES

A client has the right to refuse either some or all the proposed community nursing services. A nominated representative (i.e. person authorised to represent the client including a guardianship or administrative order, Power of Attorney, legal representative etc.) can also refuse some or all the proposed community nursing services on behalf of the client.

If community nursing services are refused, the Community Nursing provider must:

- inform the client of the expected consequences of refusal
- notify the client's GP and nominated representative (where relevant) of the refusal and
- document the refusal and the actions undertaken as a result of the refusal in the client's care documentation.

A client's refusal of community nursing services on a previous occasion does not exclude the client from accessing community nursing services in the future.

10.6 CLIENT NOT RESPONDING

The Community Nursing 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 Community Nursing provider personnel arrives for a scheduled service visit. The plan of action should include a contact person and phone number for a welfare check of the client to be conducted.

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.

Community Nursing providers should have a reminder system in place to minimise situations where a client forgets about a service visit. Where the Community Nursing provider has not activated an individual or generic client not responding plan to check the client's safety, the Community Nursing provider must not claim a visit. For further information about claiming for visits in this situation, see [Section 7.6 – 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.

Where required or requested by the client, the Community Nursing provider must ensure carers are recognised as partners in the client's care and are involved in the coordination of services.

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 Community Nursing provider should take all practicable measures to ensure that its personnel and any subcontracted organisations 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
- the Aged Care Charter of Rights
- the Aged Care Quality Standards
- the Australian Charter of Healthcare Rights, which lists rights and responsibilities for everyone receiving health care in Australia.

The *Carer Recognition Act 2010* is available at:
<https://www.legislation.gov.au/Details/C2010A00123>.

11 Performance monitoring

All Community Nursing providers are subject to performance monitoring processes. The purpose of performance monitoring is to measure compliance with contractual requirements, including both administrative and clinical requirements, and determine the quality of community nursing services being delivered. Performance monitoring will include a combination of contract management activities, quality and safety audits and post payment monitoring processes.

11.1 QUALITY AND SAFETY AUDITS

Quality and safety audits are conducted to assess the quality and safety of nursing services delivered by Community Nursing providers.

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

As part of the quality and safety audit process, Community Nursing providers will be asked to provide evidence of compliance with relevant quality standards and adherence to the Notes and contractual arrangements.

Assessment will be undertaken through a desktop review or onsite visits. It is intended providers will be audited on a three yearly cycle, however this is subject to change based on a number of factors, including service delivery claiming patterns and any issues which may arise over time.

DVA will notify the provider ahead of the audit, with the notification including the documentation requested as part of the audit. Audits will include a post payment monitoring component.

11.2 RECOGNITION OF APPROVAL OR REGISTRATION

DVA will recognise a Community Nursing provider's approval as an Aged Care provider with the Aged Care Quality and Safety Commission (ACQSC) (www.agedcarequality.gov.au). This recognition is based on the adaption of the strengthened aged care quality standards for DVA's Community Nursing Program, similarities between the compliance measures, and DVA's performance monitoring process. Aged Care approval status does not replace any DVA performance monitoring process.

While DVA recognises Community Nursing providers utilise other quality and accreditation frameworks (healthcare and non-healthcare focused), these are not currently recognised in the quality and safety audit process.

11.3 POST PAYMENT MONITORING

Post payment monitoring utilises claiming data to validate assessment and classification within the Schedule of Fees. The key objectives are to:

- ensure compliance with the Notes and Schedule of Fees
- monitor the appropriateness of claims relating to the services provided to clients
- minimise the risk of claiming errors or fraud.

12 Interaction with other health and community support service providers

12.1 VETERANS' HOME CARE (VHC) PROGRAM

A Community Nursing provider can deliver community nursing services to a client receiving domestic assistance, home and garden maintenance, or respite services under the DVA VHC Program. All referrals for VHC services must be made to a VHC Assessment Agency. The contact number for the VHC Assessment Agency 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 and the client does not have a clinical need for community nursing services, the personal care services should be provided through VHC.

A client should not receive ongoing personal care services under VHC while they are also receiving community nursing services for a clinical and/or personal care need. All the required personal care services should be delivered as a part of the community nursing services, see [Section 5.1.1 – Assessment of Personal Care Needs](#).

12.1.1 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 Community Nursing Program. To request an exemption, providers should contact DVA, see [Section 1.5 – 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 community nursing services through the Community Nursing Program, but the prospect of receiving these personal care services from a different provider through the Community Nursing Program causes a high level of stress and anxiety or
- where the client is located in an area where the only Community Nursing 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 Community Nursing 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 community nursing services.

12.2 CREDENTIALLED DIABETES EDUCATORS

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

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

12.3 OPEN ARMS – VETERANS AND FAMILIES COUNSELLING

Open Arms provides free and confidential counselling, group programs and peer support to anyone who has served at least one day of continuous fulltime service in the Navy, Army or Air Force, and their immediate families who are feeling angry, upset, anxious, depressed, or having thoughts of self-harm.

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:

- counselling for individuals, couples and families
- 24-hour telephone support
- care coordination for complex needs
- Lived Experience Peer support
- 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/>.

12.4 DEPARTMENT OF HEALTH AND AGED CARE AND OTHER PROGRAMS

12.4.1 Home Care Packages Program

The Department of Health and Aged Care (DHAC) Home Care Packages (HCP) Program supports older people with complex needs to stay at home. The HCP Program provides a continuum of four home care options covering basic home care through to high level home care:

- HCP Level 1 - Basic care
- HCP Level 2 - Low level care
- HCP Level 3 - Intermediate level care
- 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.

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 an HCP on an assumption that DVA will provide for all their care needs. To receive an HCP, a client, as any other member of the community, must have an assessment provided through My Aged Care.

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

Further information can be accessed online at: [Home Care Packages Program | Australian Government Department of Health and Aged Care.](#)

12.4.2 Commonwealth Home Support Programme

The DHAC Commonwealth Home Support Programme (CHSP) aims to help older Australians access entry-level support services to live independently and safely at home.

Further information can be accessed online at: [Commonwealth Home Support Programme \(CHSP\) | Australian Government Department of Health and Aged Care.](#)

12.4.3 Short-Term Restorative Care Programme

The DHAC Short-Term Restorative Care (STRC) Programme provides early intervention to reverse or slow 'functional decline' in older people.

'Functional decline' is when a person is having difficulty performing their day-to-day activities, including bathing, dressing, feeding, shopping and driving.

The STRC Programme provides services to older people for up to 8 weeks (56 days) to help them delay or avoid long-term care. A client can access 2 episodes of STRC within a 12-month period.

More information on STRC can be found at the following link:

[About the Short-Term Restorative Care \(STRC\) Programme | Australian Government Department of Health and Aged Care.](#)

Under the no duplication of care policy, eligible persons are able to access services through both DVA funded community nursing and the DHAC funded HCP, CHSP and STRC Programs providing there is no duplication in the services being delivered. Where a client is in receipt of both DVA funded community nursing and an HCP and/or CHSP and/or STRC, the providers delivering the programs must liaise to coordinate the care being delivered.

12.4.4 Transition Care Programme

A Community Nursing provider *cannot* deliver community nursing services to a client who is receiving Transition Care services administered by DHAC.

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

To enter Transition Care, clients may require an assessment from a My Aged Care 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 3.2.2 – Referrals from hospitals](#) for information relating to referrals to a Community Nursing provider following a hospital stay.

12.4.5 State/Territory or local based community services

A Community Nursing provider can deliver community nursing 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 community nursing services. Where a client is in receipt of community nursing services as well as State/Territory or local based services, the providers must liaise to coordinate the care being delivered.

Attachment A – Exceptional Case process

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

Prior approval must be sought from DVA through the EC process and approval given before the commencement of care outside the Schedule of Fees. EC applications may be reviewed by DVA Nursing Advisers. DVA is not liable to pay for any services that have been delivered before prior approval has been given.

As prior approval is required for all EC applications (including increases to EC care), it is recommended that the application is submitted at least one week prior to the requested commencement date to allow time for processing of the application. EC applications cannot be backdated.

Where urgent circumstances apply in regard to the commencement of care, and prior approval is not able to be obtained, interim approval can be sought. This is to ensure the appropriate care is in place for the client whilst the provider is completing and submitting the requested documentation.

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, up to a maximum of 12 months. If further EC funding is required after 12 months, a new EC application must be submitted 28 days prior to the expiry of the current EC approval. As care needs change over time, where appropriate the funding will return to the Schedule of Fees. DVA is not liable to pay for any services that have not been given prior approval through the EC process.

The Community Nursing provider should also facilitate an Aged Care assessment for any client over 65 years with complex care needs. More information about ACAT assessments can be found at the following link:

www.myagedcare.gov.au/eligibility-and-assessment/acet-assessments.

Interim Approval

Where urgent circumstances apply regarding the commencement of care, the Community Nursing provider must contact DVA via secure email to exceptional.cases@dva.gov.au, to seek urgent interim approval. The Community Nursing provider must outline the following information to enable consideration of urgent interim approval:

- Overview of urgent circumstances
- Care details – type of care, number of visits and duration, number of personnel required
- For end-of-life care requests – advice from palliative care specialist or team indicating the phase of palliation.

At DVA's discretion, interim approval can be granted for a short period of time to ensure the appropriate care is in place for the client whilst the Community Nursing provider prepares and submits the EC application with supporting documentation. DVA will provide interim approval in writing via secure email to the Community Nursing provider.

1 Exceptional Case applications

It is the responsibility of the Community Nursing provider to submit a complete EC application signed by the RN conducting the assessment, including all required attachments as detailed in the relevant EC form/s. Submission of incomplete applications will delay the assessment and processing of the application.

All applications must include:

- a copy of the current nursing care plan which must be signed by the RN and the client or their nominated representative
- a GP health summary and referral, or a referral from a treating medical practitioner in a hospital, or a hospital discharge planner.

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/EN or assisted by a PCW. A current medication authority and/or medication chart signed by the treating medical practitioner must be attached for administration and/or assistance of medications
- any aids, appliances, or nursing equipment required to successfully complete interventions
- the short and long term goals and objectives to successfully resolve and manage each identified nursing need
- the level of personnel needed to successfully complete each planned intervention
- referrals to allied health and other health professionals as clinically indicated
- the frequency and length of time needed for visits
- the agreed visit days and approximate timeframes
- planned review dates as per [Section 8 – Review of Care](#), and any additional requirements as identified from the nursing assessment.

Nursing care plans must be signed by the RN and the client or their authorised representative.

If a client is identified as having potential EC status, the Community Nursing provider must maintain the existing 28-day claim cycle start date 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. Where a Community Nursing provider delivers services under the Schedule of Fees whilst awaiting the outcome of an application for EC status, services delivered will be taken into consideration when assessing the EC application.

Applications must be submitted via DVA secure email. To set up secure email facilities, please email exceptional.cases@dva.gov.au. Further information about secure email is available on the DVA website at [Sensitive emails](#).

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

1.1 EXCEPTIONAL CASE FORMS

All EC forms are available on the DVA website at [Exceptional Cases](#).

Forms should be completed electronically where possible. If forms are completed manually, black pen should be used.

D1004 - Application for Exceptional Case status – this form is used for new EC applications, and applications to continue care beyond the end of an existing EC approval period.

D1004A - Attachment 1 – Dementia – this form is to be used as an attachment to an EC application where the client has been diagnosed with dementia.

D1004B - 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.

D1004C - 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.

D1004D - Attachment 4 – Wound Care – this form is to be used as an attachment to an EC application where wound care is being provided, or as an attachment to a Nursing Consumables over \$1,000 form where consumables were required for wound care. It must also include a wound care plan (if separate to the nursing care plan) and current wound images.

D9384 - Exceptional Case Interruption to Care – this form is to be 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 approved period of EC status, an adjustment may be made to the fee paid for the 28-day claim period during the period the interruption occurred. If the client has been absent from care for more than 28 days, for whatever reason, they must be discharged from community nursing services. See [Section 9 – Discharge from Community Nursing Services](#).

A new application must be submitted for assessment if the client requires EC status on readmission to the provider's care.

D1307 - Exceptional Case Variation Form – this form is used to request a variation to a client's approved EC care. This notification must be received prior to the request for increased care or within seven business days of the date the decrease to care commenced.

D9297 - Request for Reimbursement 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 must include itemised evidence of expenditure. If the consumables claim is in relation to wound care, the *D1004D Attachment 4 – Wound Care* form, wound care plan, and current wound images must also be provided.

Community Nursing 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 Community Nursing 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 business days of receipt of a complete application, 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 of the application. DVA will contact the Community Nursing provider by secure email to notify them that the application is unable to be processed. An Unable to Process letter requesting the necessary information including any timeframes will be sent to the Community Nursing provider.

If the requested information is not provided within the requested timeframes, the existing application will be closed and the provider will need to submit a new EC application.

It is the responsibility of the Community Nursing provider to submit 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

As part of processing an application, DVA will assess whether a client meets the requirements for EC status. A DVA representative may contact the Community Nursing 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
- 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 Community Nursing 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 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 Community Nursing 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, DVA will issue an approval letter to the Community Nursing provider. The approval letter will include:

- approved care period dates
- the number of community nursing visits per 28-day claim period covered by the approval, for each level of personnel providing the assessed care
- the item number to be claimed for each 28-day claim period covered by the approval

- the 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.

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

If DVA identifies the community nursing services being delivered do not meet contemporary evidence based practice, DVA may request further supporting information and/or make recommendations in relation to the care provided.

Following the application of indexation to community nursing fees, a subsequent approval letter will be sent for each existing EC approval that extends beyond the indexation date, detailing funding information for the remaining claim periods covered by the approval.

2 Appeals process

The EC process includes an appeals mechanism. In considering an appeal, the Community Nursing provider must note that:

- a Community Nursing provider cannot appeal on financial grounds and
- 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 Community Nursing provider should forward in writing the reason for the appeal. The appeal should be lodged with the Assistant Director - Operations 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 Community Nursing provider of the outcome of the appeal within ten business 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 Community Nursing provider.

If the appeal is disallowed the original decision stands.

If the Community Nursing provider does not want to continue to deliver services to the client on the basis of the funding decision, the provider must inform DVA so that consideration can be given to alternative provider options.

Attachment B – Additional Travel

1 Overview

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

Where Community Nursing providers undertake an exceptional amount of travel to deliver required community nursing services to clients living in regional or remote areas (as classified under the Modified Monash Model), this travel might not be covered by the Schedule of Fees and EC classification item numbers.

To ensure that Community Nursing providers are adequately compensated for the travel to deliver community nursing 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 Community Nursing provider may not claim for travel for a client under the Additional Travel item if they are not the nearest suitable Community Nursing provider.

For Additional Travel purposes the nearest suitable provider also includes the location of its personnel. For example, one of the Community Nursing provider's personnel may live closer to the client than the Community Nursing provider's head office, in this case the personnel living closest to the client should be considered in providing 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
- for distances of over 20 kilometres from the community nursing personnel's final departure point to the client's home.

A kilometre-based travel payment is not paid:

- if the Community Nursing provider is already receiving additional travel for another client in the same region who is visited on the same day
- if there is another suitable provider closer to the client's home
- if the distance is 20 kilometres or less for each segment of the community nursing personnel's journey.

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 Schedule of Fees or EC items.

Additional travel is funded retrospectively. Claims should deduct the first 20 kilometres of each segment of the personnel's journey, and calculate the total number of eligible kilometres travelled during the 28-day claim period.

The Community Nursing provider should submit claims for payment of Additional Travel using the Other Items – Additional Travel item number (NA10), in conjunction with other relevant item number/s for services provided during the claim period.

Attachment C – Palliative Care Phases

1 Palliative Care

The primary care team (including the Community Nursing 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 symptoms or issues experienced are complex, or beyond the capabilities of the primary care team. This scenario may vary depending on the State or Territory in which the Community Nursing provider operates or the client resides.

The palliative care phase is a stage of the client's illness and can provide a clinical indication of the level of care required. Palliative care phases are not sequential and a client may move back and forth between phases. Phases are defined in terms of the below criteria as these highlight the essential issues to be considered when assigning a phase. 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/>. Additional information and educational resources can be found at: Palliative Care Outcomes Collaboration (PCOC) University of Wollongong. <https://ahsri.uow.edu.au/pcoc/index.html>.

1.1 PHASE 1: STABLE

A client will not usually require high levels of interventions in this phase. Symptoms are adequately controlled by established management. Further interventions to maintain symptom control and 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

A client generally requires high levels of interventions in the short term in this phase.

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

A client may require high levels of interventions to enable them to remain at home in this phase.

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

A client will usually require interventions aimed at physical and emotional issues, and/or requires overnight nursing care in the short term.

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 and 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 BEREAVEMENT

The 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.

Attachment D – Nursing Consumables

1 Overview

The following information outlines the methods and processes that Community Nursing providers can use to obtain nursing consumables for clients. Where products are available through either the Repatriation Pharmaceutical Benefits Scheme or Rehabilitation Appliances Program, a Community Nursing provider cannot claim for these items under Nursing Consumables.

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 medical practitioner.

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 and equipment to assist clients to maintain their independence at home. Aids or equipment prescribed through RAP can include:

- 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 [Rehabilitation Appliances Program](#).

1.3 CLAIMING FOR NURSING CONSUMABLES \$1,000 AND UNDER

A range of 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

Where the total cost of eligible nursing consumables used for a client exceeds \$1,000 (exclusive of GST) in a 28-day claim period, Community Nursing providers can seek reimbursement by applying via the EC process. See [Attachment A – Request for Funding of Nursing Consumables Over \\$1,000](#). There is an upper limit of \$1,500 for consumables per 28-day claim period.

Substantiation of consumables and amounts used, and itemised costs in the 28-day claim period must accompany the EC form.

1.5 CLAIMING RULES

- a. The Community Nursing 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 for products used in the provision of care to the client in a 28-day claim period.
- b. The Community Nursing 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.
- c. 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 Community Nursing 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.
- d. DVA does not pay for the cost of delivery of nursing consumables to a client.
- e. Community Nursing 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.
- f. Community Nursing 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
 - items which are covered in the cost of the visit, including the [‘nurse’s toolbox’](#).
- g. A Nursing Consumables item number must be claimed in conjunction with a Clinical Care item number.
- h. Only one Nursing Consumables item number can be claimed per 28-day claim period for a client.
- i. MDS is not required for Nursing Consumables item numbers.
- j. The Community Nursing provider must retain nursing consumables records in the client’s file to be able to substantiate any payment of Nursing Consumables item numbers for future performance monitoring review or quality and safety audit requests or processes.

1.6 NURSE’S TOOLBOX

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 Veteran Gold Card holders, including veterans, war widows/widowers and dependants who have one or more chronic conditions, and for Veteran White Card Holders with a mental health condition for which DVA has accepted liability (a DVA-accepted mental health condition) which is chronic. To be eligible, 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 care coordinator. The care coordinator may be a Practice Nurse, Aboriginal and/or Torres Strait Islander Primary Health Care Worker or community nurse working for a DVA contracted Community Nursing provider. The GP and care coordinator work together with the client and their carer if applicable and other members of the Care Team including other health care providers who are delivering services to the client.

Enrolled participants will receive support through the provision of comprehensive, coordinated and ongoing care with the assistance of a care coordinator. The CVC Program involves a proactive approach to improve the management of participants’ chronic conditions and quality of care.

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 receive coordination of 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.

Further information about the CVC Program is available at: www.dva.gov.au/cvc.

1.1 NOTES FOR COORDINATED VETERANS’ CARE PROGRAM PROVIDERS

The [Notes for Coordinated Veterans’ Care Program Providers](#) define the parameters for coordinating health care treatment under the CVC Program for 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 (GP)
- b) Registered Nurses (RN)/Enrolled Nurses (EN) employed by the GP practice (Practice Nurses)
- c) Aboriginal and/or Torres Strait Islander Primary Health Care Workers
- d) Community nurses employed by DVA contracted Community Nursing providers.

1.2 COMMUNITY NURSING CARE COORDINATION COMPONENT

If a Community Nursing provider identifies that a Veteran Gold Card holder or Veteran White Card holder with a DVA-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

Where a Community Nursing provider has been appointed by the GP as the care coordinator, the care coordination provided under the CVC Program:

- must be delivered by either an RN or an EN
- must be delivered by personnel with appropriate qualifications and experience.

Where CVC care coordination activities are delivered by an EN, this must be appropriately delegated, supervised and documented by an RN.

1.2.2 Record keeping

The Community Nursing provider must keep comprehensive clinical records in accordance with existing requirements in [Section 5.2 – Care Documentation](#). This should include a copy of the CVC Care Plan signed by the participant, GP and care coordinator.

Full details of all care coordination and contact activities must be recorded and placed on the participant's file.

1.2.3 Claiming

All claims for payment for CVC care coordination services provided to a CVC participant are paid by Services Australia (Medicare) on behalf of DVA.

Once the GP enrolls an eligible 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 community nursing care coordination services can be made.

1.2.4 Item numbers

There are two CVC Program item numbers in the Schedule of Fees:

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

This item must have a claim start date which is later than the date the Veteran Gold Card holder or Veteran White Card holder with a DVA-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.

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

When claiming the *CVC Community Nursing – Subsequent Care Coordination* item number, the Community Nursing 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 Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition, where the participant is also receiving community nursing services.

Where a CVC participant is hospitalised during a claim period, the following rules apply:

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

During hospitalisation, the care coordinator must:

- as a minimum, liaise with the GP to:
 - contact the hospital to advise that the Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition is a participant in the CVC Program and request to be advised of the expected discharge date
 - participate if possible in the hospital discharge planning process;
- request a copy of the discharge papers from the GP
- once discharged, contact the Veteran Gold Card holder or Veteran White Card holder with a DVA-accepted mental health condition to review the comprehensive Care Plan
- document all care coordination activity in accordance with the existing requirements in [Section 5.2 – Care Documentation](#).

1.2.5 Death of a CVC participant

Where a CVC participant dies partway through a claim period, the Community Nursing provider can claim the Community Nursing – Subsequent Care Coordination item number for the 28-day claim period in which the death occurred, provided CVC care 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 Community Nursing 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 CVC care 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 Schedule of Fees that cannot be claimed with CVC Coordination item numbers are:

- NA99 – Assessment Only; and
- NL01 and NL02 – Clinical Support.

Item number NA02 (Assessment - Ongoing services required) cannot be claimed if item number UP05 (CVC Initial Care Coordination) has been claimed in the same period.

All other item numbers in the Schedule of Fees can be claimed in conjunction with the CVC Program item numbers, if appropriate.