AUSTRALASIAN REHABILITATION OUTCOMES CENTRE

PAEDIATRIC DATA DICTIONARY v 1.04

FOR CLINICIANS - AUSTRALIAN VERSION

For technical queries regarding this document or for more information, please contact the AROC team.

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Paediatric Data Dictionary v1.04 for Clinicians – Australian version

BACKGROUND

This data dictionary includes all of the data items that are in the AROC Paediatric V1 dataset. Each data item is listed, along with the definition, justification and guide for use. The language and information is aimed to assist clinically trained staff in using and understanding the AROC data. AROC recommends that this dictionary is used as a support document for staff members collecting data on our data collection forms. If you find that this dictionary does not adequately clarify your query of a data item, please contact aroc@uow.edu.au.

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PAEDIATRIC DATA DICTIONARY VERSION

Version	Date	Data item	Nature of change
1.04	Apr 2021	Interim accommodation support at episode end	In home support provided by family note added
		Final accommodation support at episode end	In home support provided by family note added
		First direct care rehabilitation episode	Changes made to definition
		Date clinically ready for discharge	Renamed to Community ready date and removed data item from Ambulatory dataset.
1.03	Jun 2019		Update to formatting.
1.02	Dec 2018	Accommodation support prior to admission	In home support split into In home support provided by family and In home support provided by external agency
		Interim accommodation support at episode end	In home support split into In home support provided by family and In home support provided by external agency
		Final accommodation support at episode end	In home support split into In home support provided by family and In home support provided by external agency
		Community support prior to admission	Codeset option for Regional resource and support teams removed
		Community support at episode end	Codeset option for Regional resource and support teams removed
		National Disability Insurance Scheme (NDIS)	New codeset value added for Covered by another insurance scheme
		AROC Impairment Code	Added information to Guide for Use.
1.01	Aug 2017		Update to formatting.
1.00	Feb 2017		Data Dictionary first published.

AROC Paediatric Data Dictionary for Clinicians V1.04 (AU)

Path

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Inpatient direct care:
Is delivered in an inpatient setting, with the child accommodated overnight in the hospital and included in the bed occupancy reporting at midnight.

This includes 'Shared Care' arrangements. For example, a child admitted to the Intensive Care Unit following a car accident is presenting as a ventilator dependent tetraplegia. This child is unable to be managed on the rehabilitation ward because of the ventilator requirements but is receiving all therapy and discharge planning through the rehabilitation team and is considered to be under a 'shared care' model.

Ambulatory direct care:
Is delivered in an ambulatory setting. Examples of ambulatory settings include day rehabilitation, outpatient departments and community based rehabilitation programs.

- Is multi-disciplinary, although all therapies may not necessarily be delivered concurrently.
- Starts with a multi-disciplinary assessment.
- Is goal oriented – includes goal setting and review.
- The program of care is time limited.

Ambulatory rehabilitation may occur as:

- The continuation of an inpatient episode of rehabilitation.
- A rehabilitation program provided solely in an ambulatory setting.

Note:

- The initial collection of ambulatory paediatric rehabilitation episodes will focus on the day rehabilitation setting.
- The AROC paediatric rehabilitation dataset does not collect information relating to outpatient clinics, e.g. Botulinum Toxin Clinics.

Justification: N/A

Guide for use: N/A

Codeset values:

3	Inpatient Direct Care
4	Ambulatory Direct Care

Establishment ID

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: A code which represents the facility.

Justification: N/A

Guide for use: This would usually be the facility code issued by the Department of Health.

Establishment name

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The name of the facility collecting and submitting the data.

Justification: N/A

Guide for use: N/A

Ward ID / Team ID

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: A 4 character alphanumeric code representing a ward or team.

Justification: 'Ward identifier' and 'Ward name' included for those facilities who have more than one ward and wish to:

1. Identify their data at ward/team level
2. Enable assignment of episodes of care to the appropriate ward/team.

Guide for use: It is not mandatory to collect this data item if the facility has only one rehabilitation ward/team.

While Ward ID is optional and can be left blank, it is required if you wish to do analysis and/or receive benchmark reports by ward or will want to at any point in the future.
If you are entering a Ward ID then it is essential that it is entered consistently and correctly for every episode – it is the Ward ID that determines which benchmark report the episode is reported in.
The actual value recorded against Ward ID is at the facility's discretion. To reduce errors in data entry AROC suggest keeping the Ward ID you use as simple as possible, i.e. use "1A", rather than "Ward 1A".

Ward name / Team name

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The name of a ward or team within a facility.

Justification: 'Ward identifier' and 'Ward name' included for those facilities who have more than one ward and wish to:

1. Identify their data at ward/team level
2. Enable assignment of episodes of care to the appropriate ward/team.

Guide for use: It is not mandatory to collect this data item if the facility only has one rehabilitation ward/team.

While Ward name is optional and can be left blank, it is required if you wish to do analysis and/or receive benchmark reports by ward or will want to at any point in the future.
The actual value recorded against Ward name is at the facility's discretion but should be consistent with every episode that is treated on that ward.

Unique record number

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Unique record number established by the facility to enable communication regarding data quality issues pertaining to that child's episode.
Justification:	This variable is required in order to facilitate communication between AROC and facilities about data quality issues.
Guide for use:	Facilities are not required or asked to provide MRN/NHI as their unique record number, only to use some code which would enable them to 'locate' the person referred to by that code in their own IT system for the purpose of correcting data quality issues.

Letters of name

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	This is a 5 letter character string made up of the 2nd, 3rd and 5th letters of the child's surname, followed by the 2nd and 3rd letters of the child's first name.
Justification:	This information forms part of the Statistical Linkage Key (SLK) used by AROC to link children's episodes through their rehabilitation journey.
Guide for use:	In the first three spaces record the 2nd, 3rd and 5th letters of the child's surname. In the following two spaces, record the 2nd and 3rd letters of the child's first name. For more information on SLK, please refer to the AROC website.

Date of birth

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date of birth of the child being treated by the facility.
Justification:	Date of birth allows generation of age which is important for analysis. It also forms part of the Statistical Linkage Key (SLK) formula used by AROC to link children's episodes throughout their rehabilitation journey.
Guide for use:	Enter in format DD/MM/YYYY. For more information on SLK, please refer to the AROC website.

Sex

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The biological differences between males and females, as represented by a code.

Justification: Collected to allow analysis of outcomes by sex.

Guide for use: Record the appropriate sex of the patient.

Codeset values:

1	Male
2	Female
3	Indeterminate
9	Not stated/inadequately defined

Indigenous status (AU)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Indigenous status is a measure of whether a child identifies as being of Aboriginal or Torres Strait Islander origin.

Justification: Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in respective societies and cultures. Accurate and consistent statistics about indigenous status are needed in order to plan, promote and deliver services. The purpose of this item is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin in Australia.

Guide for use: Record the appropriate indigenous status.

Codeset values:

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

Geographical residence (AU)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Geographical residence is the state in which the child usually resides.

Justification: This information may be used for identification of referral patterns and for analysis of outcomes by geographical area.

Guide for use: Record the state in which the child usually resides.

Codeset values:

1	NSW
2	VIC
3	QLD
4	SA
5	WA
6	TAS
7	NT
8	ACT
9	Other Australian Territory
10	Not Australia

Postcode

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	Postcode is the numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of child.
Justification:	This information may be used for identification of referral patterns and for analysis of outcomes by geographical area.
Guide for use:	Record the postcode of the child's usual place of residence. Record 8888 for not applicable. Record 9999 for unknown.

Episode begin date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

This is the date the child commenced rehabilitation care. This date defines the beginning of the rehabilitation episode and is the date from which length of stay (LOS) calculation begins. This is not dependent on geography or location of the child.

The begin date for an inpatient direct episode of care, is the date that the child's care is transferred to a rehabilitation physician or physician with an interest in rehabilitation and it is recorded in the medical record that the rehabilitation team has commenced the rehabilitation program/provision of care. It is the date that the "care type" becomes rehabilitation, no matter where the child is geographically located. This date may be the same as the date the child was admitted to hospital e.g. a child admitted from home directly onto the rehabilitation unit or a date during their hospital stay e.g. date the child's care was transferred to a rehabilitation physician and rehabilitation commenced whilst the child remained on the acute ward awaiting a rehabilitation bed.

The episode start date for 'shared care' is the date the rehabilitation team starts working with the child, regardless of the admitting medical team e.g. rehabilitation for a child with an ABI whilst under the care of the acute neurosurgical team.

The begin date for an ambulatory direct episode of care, is the date that the child's care is transferred to a rehabilitation physician or physician with an interest in rehabilitation and it is recorded in the medical record that the ambulatory rehabilitation team has commenced the rehabilitation program/ provision of care.

Justification:

This item is required to establish time periods between critical points throughout the rehabilitation episode.

Guide for use:

Record the date that the child commenced rehabilitation care.

Episode end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The date that the child completed their rehabilitation episode. This date defines the end of the rehabilitation episode and is the date at which the length of stay (LOS) concludes.
The inpatient rehabilitation episode ends when the child is discharged from the rehabilitation unit and/or the care type is changed from rehabilitation to acute or some other form of sub-acute care e.g. maintenance, no matter where the child is physically located (rehabilitation ward/acute ward).
The ambulatory rehabilitation episode ends when the child is discharged from the ambulatory rehabilitation program and/or the care type is changed from rehabilitation to either acute or some other form of sub-acute care e.g. palliative care.

Justification: This item is required to establish time periods between critical points throughout the rehabilitation episode.

Guide for use: Record the date that the child completed their rehabilitation episode or when the child is discharged from rehabilitation.

Funding source (AU)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The principal source of funding for the child's rehabilitation episode.

Justification: Collection of this data item enables AROC to distinguish rehabilitation episodes of care based on funding sources of health fund or other payer.

Guide for use: If there is more than one contributor to the funding of the episode, please indicate the major funding source. If funding source = 2, 4 or 5 then complete related data item D12, Health fund/other payer.

Codeset values:

1	Australian Health Care Agreement (public patient)
2	Private Health Insurance
3	Self-funded
4	Workers compensation
5	Motor vehicle third party personal claim
6	Other compensation (e.g. public liability, common law, medical negligence)
7	Department of Veterans' Affairs
8	Department of Defence
9	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal health care agreement (other countries)
98	Other
99	Not known

Health fund/other payer

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Code corresponding to the child's private health fund, workers' compensation insurer or Compulsory Third Party (CTP) insurer as listed in codeset below.

Justification: Collection of this data item enables AROC to distinguish rehabilitation episodes of care based on the funding sources of health fund or other payer.

Guide for use: Code corresponding to the child's private health fund, workers' compensation insurer or Compulsory Third Party (CTP) insurer as listed below.

Only complete if "funding source" = 2 private health insurance, 4 workers' compensation or 5 motor vehicle third party personal claim.

Codeset values:

1	ACA Health Benefits Fund
2	The Doctor's Health Fund Ltd
11	Australian Health Management Group
13	Australian Unity Health Limited
14	BUPA Australia Health Pty Ltd (trading as HBA in Vic & Mutual Community in SA)
18	CBHS Health Fund Limited
19	Cessnock District Health Benefits Fund (CDH benefit fund)
20	CUA Health Ltd
22	Defence Health Limited
25	Druids Friendly Society - Victoria
26	Druids Friendly Society - NSW
29	Geelong Medical and Hospital Benefits Assoc Ltd (GMHBA)
32	Grand United Corporate Health Limited (GU Health)
37	Health Care Insurance Limited
38	Health Insurance Fund of Australia
40	Healthguard Health Benefits Fund Ltd (trading as Central West Health, CY Health & GMF Health)
41	Health Partners
46	Latrobe Health Services Inc.
47	Lysaght Peoplecare Ltd (Peoplecare Ltd)
48	Manchester Unity Australia Ltd
49	MBF Australia Ltd
50	Medibank Private Ltd
53	Mildura District Hospital Fund Limited
56	Navy Health Ltd
57	NIB Health Funds Ltd
61	Phoenix Health Fund Ltd
65	Queensland Country Health Ltd
66	Railway & transport Health Fund Ltd (rt Healthfund)
68	Reserve Bank Health Society Ltd
71	St Luke's Medical & Hospital Benefits Association Ltd
74	Teachers Federation Health Ltd
77	HBF Health Funds Inc
78	HCF - Hospitals Contribution Fund of Australia Ltd, The
81	Transport Health Pty Ltd
83	Westfund Ltd
85	NRMA Health (MBF Alliances)
86	Queensland Teachers' Union Health Fund Ltd
87	Police Health

91	Onemedifund
92	health.com.au (HEA)
93	CBHS Corporate Health Pty Ltd
94	Emergency Services Health Pty Ltd
95	Nurses & Midwives Health Pty Ltd
96	MyOwn
401	WorkCover Qld
402	Allianz Australia Workers Compensation
403	Cambridge Integrated Services Vic Pty Ltd
404	CGU Workers Compensation
405	JLT Workers Compensation Services Pty Ltd
406	QBE Worker's Compensation
407	Wyatt Gallagher Bassett Workers Compensation Victoria Pty Ltd
408	Employers' Mutual Indemnity
409	GIO Workers Compensation (NSW)
410	Royal & Sun Alliance Workers Compensation
411	CATHOLIC CHURCH INSURANCES LTD
412	GUILD INSURANCE LTD
413	INSURANCE COMMISSION OF WA
414	Zurich Australia Insurance Ltd
415	WESFARMERS FEDERATION INSURANCE LTD
416	Territory Insurance Office
417	ComCare
418	Victoria Workcover Authority
601	Allianz Australia Insurance Ltd
602	Australian Associated Motor Insurers Ltd
603	QBE Insurance (Australia)
604	Suncorp/Metway
605	RACQ Insurance Ltd
606	NRMA Insurance Ltd
607	Transport Accident Commission Vic
608	AAMI
609	CIC
610	GIO
611	QBE
612	Zurich
613	Insurance Commission of Western Australia
614	Motor Accident Insurance Board Tasmania
615	Territory Insurance Office NT
616	SGIC General Insurance
999	Unknown (enter in comments)

National Disability Insurance Scheme (NDIS)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

The National Disability Insurance Scheme (NDIS) is an Australian government scheme which will provide funding supports, which are required due to a person's disability which will assist the participant to undertake activities of daily living, for eligible participants.

Justification:

The NDIS supports the provision of aids and equipment, items such as prosthetics, home modification, personal care and domestic assistance. Determining a child's eligibility for the NDIS and organising supports can be a lengthy process. Analysis of this item will help to identify whether there are delays in accessing NDIS funds and the potential impact on the child's rehabilitation program.

NOTE: The NDIS commenced progressive introduction in all Australian states and territories in July 2016, and progressive roll out of a nationally consistent but state-run NDIS in Western Australia commencing July 2017.

Guide for use:

Record the eligibility status of the person within the NDIS at the completion of their rehabilitation episode.

Codeset values:

1	Eligible - on a plan
2	Eligible - waiting
3	Awaiting eligibility determination
4	Eligible - hasn't applied
5	Covered by another insurance scheme
8	Not Eligible/Not Relevant

Paediatric AROC impairment code

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The AROC impairment codes are used to classify rehabilitation episodes into like clinical groups. The paediatric impairment codes were created to reflect the Australia/New Zealand clinical environment. The selected code should reflect the primary reason for the current episode of rehabilitation care.

Justification: Classification into like clinical groups provides a basis for analysing outcomes for clinically homogenous types of patient rehabilitation episodes.

Guide for use: The AROC Paediatric Impairment Coding Guidelines provide assistance in correctly classifying rehabilitation episodes according to impairment groups.

Please note:
1. The episode should be classified according to the primary reason for the current episode of rehabilitation care.
2. Rehabilitation program names related to funding are not necessarily the same as the impairment group names.

The AROC Paediatric Impairment Coding Guidelines are available on the AROC website (www.aroc.org.au) under "Tools and Resources".

Example:
Encephalopathy code as 2.14 - Brain Dysfunction - Non traumatic - Other
TBI plus visual disturbance or TBI plus #bilateral wrists code as 2.23 - Brain Dysfunction - Traumatic - Major Multiple Trauma with brain injury.
A major multiple trauma plus a spinal injury code as 4.2 - Spinal cord dysfunction - Traumatic

Codeset values:

1.1	Stroke - haemorrhagic
1.2	Stroke - other (including ischaemic)
2.11	Brain Dysfunction: Non traumatic - Brain tumour
2.12	Brain Dysfunction: Non traumatic - Epilepsy surgery
2.13	Brain Dysfunction: Non traumatic - Chronic Fatigue Syndrome
2.14	Brain Dysfunction: Non traumatic - Other (to include Hypoxic brain injury)
2.21	Brain Dysfunction: Traumatic - Open injury
2.22	Brain Dysfunction: Traumatic - Closed injury
2.23	Brain Dysfunction: Traumatic - Major multiple trauma with brain injury
3.1	Multiple Sclerosis / ADEM
3.2	Guillain-Barre Syndrome
3.3	Movement disorders (includes cerebral palsy, extrapyramidal movement disorders and other movement disorders)
3.4	Neuromodulation (includes ITB and DBS)
3.5	Other (includes neuropathies and neuromuscular disorders)
4.1	Spinal cord dysfunction: Non-traumatic (includes transverse myelitis)
4.2	Spinal cord dysfunction: Traumatic
4.3	Spinal cord dysfunction: Congenital (includes Spina Bifida / neural tube deficits/ sacral agenesis)
4.4	Spinal cord dysfunction: Post Selective Dorsal Rhizotomy
5.11	Amputation: Non traumatic - Upper limb
5.12	Amputation: Non traumatic - Lower limb
5.13	Amputation: Non traumatic - Multiple limbs
5.21	Amputation: Traumatic - Upper limb
5.22	Amputation: Traumatic - Lower limb
5.23	Amputation: Traumatic - Multiple limbs
6.1	Orthopaedic conditions: Acute traumatic (including fractures)
6.21	Orthopaedic conditions: Scoliosis surgery (not Spina Bifida or spinal cord dysfunction)
6.22	Orthopaedic conditions: SEMLS

6.23	Orthopaedic conditions: Other planned
7	Burns
8	Arthritis
9	Pain syndromes
10	Loss of function without known aetiology
11.1	Reconditioning post-acute stay
11.2	Other

Date of injury/impairment onset

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:
The date of the injury or impairment that has directly driven the need for the current episode of rehabilitation. For example, the date the child had a brain injury, or the date the child had a stroke, or the date the child had a limb amputated.

Justification:
This item is collected to measure the time between injury/impairment and admission to rehabilitation, and enable analysis against outcomes achieved.

Guide for use:
This data element is one of a data pair and is only collected if the exact date of injury/impairment is known. If the exact date is unknown, leave blank and record data item “Time since onset or acute exacerbation of a chronic condition” instead. Do not record both items within this data pair.

Example:
If a child has surgery to remove a brain tumour, or oncology management and then subsequent surgery, then record the date of surgery as the date of injury/impairment onset.

Time since onset or acute exacerbation of chronic condition

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

The time that has elapsed since the onset of the child's condition that is the reason for this episode of rehabilitation care.

Justification:

This item is collected to measure the time between injury/impairment and admission to rehabilitation, and enable analysis against outcomes achieved.

Guide for use:

This data element is one of a data pair and is only collected if the exact date of injury/impairment is not known or the reason for rehabilitation is not related to an acute injury/ impairment. Record this data item or date of injury/impairment, not both.

In some cases, the impairment that has driven the need for rehabilitation may be a chronic disease with an insidious onset. In these cases, record when the impairment started affecting the child's function. For example, a child admitted for rehabilitation for ADEM which started affecting the child's functioning three weeks ago: record codeset "less than one month ago".

Codeset values:

1	Less than one month ago
2	1 month to less than 3 months
3	3 months to less than 6 months
4	6 months to less than a year
5	1 year to less than 2 years
6	2 years to less than 5 years
7	5 or more years
9	Unknown

Referral date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The date that the rehabilitation team received a referral for the child.

Justification: This item is collected to measure the impact of delay between the date a referral was received and the date rehabilitation started. Please note: Date referral received is being collected and not the date the referral was made, because at times these dates may differ and it was deemed inaccurate to include these extra days in the analysis. Under other circumstances, date referral received and date referral made will be the same.

Guide for use: Record the date the referral was received.
Across the services referrals can be made in multiple ways including face-to-face, in writing, by telephone, fax or email.

Example:
A child who is an inpatient on the Intensive care ward was considered to be clinically ready for rehabilitation on 01/02/2012. A clinician on the intensive care ward calls the rehabilitation ward and makes a verbal referral the same day. Record 01/02/2012, the date the referral was received by the rehabilitation ward.

A child who was an inpatient will require day program therapy once discharged. A referral was made after hours by fax on 01/02/2012, but only received by the day program service on 02/02/2012. Record 02/02/2012, the date the referral was received by the day program service.

Date clinically ready for rehabilitation care

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	A child is “clinically ready for rehabilitation care” when the rehabilitation physician, or physician with an interest in rehabilitation, deems the child ready to start their rehabilitation program and have documented this in the child's medical record.
Justification:	This item is collected to flag episodes that experienced a delay between being clinically ready for rehabilitation and rehabilitation actually starting.
Guide for use:	Record the date the child is deemed clinically ready for rehabilitation.

Was there a delay in episode start?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item identifies whether there was a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program commencing.

Justification: This item is collected to flag episodes that experienced a delay in their rehabilitation start.

Guide for use: Record 1,“Yes” if there was a delay and 2, “No” if there was not. If “Yes”, complete the next 5 questions about reason(s) for delay in episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Patient related issues (medical)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item collects information about patient related medical issues that have caused a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program commencing.

Justification: This item enables identification of rehabilitation episodes where rehabilitation end was delayed because the child's condition was medically unstable.

Guide for use: Example:

The child is not medically stable; assessed as appropriate for rehabilitation, but has developed fevers and can only be admitted once afebrile for 48 hours or the child requires further medical examination, investigation or tests, which cannot be provided on the rehabilitation unit.

If you would like to record additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Service issues (hospital)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item collects information about service issues (hospital) that have caused a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program starting.

Justification: This item enables identification of rehabilitation episodes whose rehabilitation start was delayed by hospital service issues.

Guide for use: Example:

There are no available hospital beds, so the child remains in a regional or remote hospital until a bed becomes available.
There are no available rehabilitation beds, so the child remains on acute ward until a bed becomes available.
There are no single rooms available for a patient requiring isolation e.g. patient has MRSA.
Physician/surgeon responsible for the child's acute admission has not agreed for patient's transfer.
There are waiting lists for access to ambulatory programs.
The hospital has no available beds, even though the rehabilitation program has capacity.

If you would like to record additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Service issues (rehabilitation department)

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item collects information about service issues that have caused a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program commencing.

Justification: This item enables identification of rehabilitation episodes whose rehabilitation start was delayed by rehabilitation department service issues.

Guide for use: Example:

No appropriate staff available; policy precludes Friday admissions because there is no provision for weekend staff to commence a rehabilitation program.

If you would like to record additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - External support issues

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

This item collects information about external support issues that have caused a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program starting.

Justification:

This item enables identification of rehabilitation episodes whose rehabilitation start was delayed by external support issues.

Guide for use:

Example:

Education regarding the clinical needs of the child to be completed prior to transfer to rehabilitation e.g. the child requires specialist wound management and staff on the rehabilitation unit need to receive this education before the child can be transferred.

Family issues delay admission to rehabilitation e.g. parents need to organise child care and/or leave from work prior to transferring to rehabilitation or alternate accommodation in the community.

Lack of availability of family/friend support, e.g. child and family need to stay with family or friend in the city in order to attend outpatient or community based therapy program. This family or friend is currently out of town and the family is still seeking alternate accommodation.

If you would like to record additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Equipment issues

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item collects information about equipment issues that have caused a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program commencing.

Justification: This item enables identification of rehabilitation episodes whose rehabilitation start was delayed by equipment issues.

Guide for use: Example:

The child requires specialist adult-sized equipment, which the ward does not have available and need to hire, prior to admission.

If you would like to record additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Patient behavioural issues

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item collects information about patient behavioural issues that have caused a delay between the child being assessed as clinically ready for rehabilitation and the rehabilitation program commencing.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation start was delayed by patient behavioural issues.

Guide for use: Example:

The child has challenging behaviours that cannot be managed in the rehabilitation unit at this time.

If you would like to record additional information, please use the General comments section.
Leave blank if you indicated that there was no delay in the episode start.

Codeset values:

1	Yes
2	No

Mode of episode start - Inpatient

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information regarding where the child's inpatient rehabilitation episode started.

Justification: This data item defines how the child commenced their inpatient rehabilitation journey. Different entry points may affect a child's progress.

Guide for use: Record the appropriate source for the inpatient rehabilitation episode.

Example:

A child can be admitted from a hospital setting or the community; either directly from their home (usual accommodation), or from somewhere other than their usual accommodation e.g. staying with friends.
Within the code set,
"Usual accommodation" is defined as the child's regular fixed abode e.g. their own home/foster care setting.
"Other than usual accommodation" is defined as temporary accommodation e.g. the child and family were away on holiday or business or visiting family and friends when injured and admitted to hospital.

Codeset values:

1	Admitted from usual accommodation
2	Admitted from other than usual accommodation
3	Transferred from another hospital – same state (AU) / DHB (NZ)
4	Transferred from another hospital – different state (AU) / DHB (NZ)
5	Transferred from under the care of a different specialty within the same hospital
6	Other

Mode of episode start - Ambulatory

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: This item records the referral source for the child's ambulatory rehabilitation episode.

Justification: This data item defines how the child commenced their ambulatory rehabilitation journey. Different entry points may affect a child's progress.

Guide for use: Record the appropriate referral source for the ambulatory rehabilitation episode.

Example:

A child may be referred from the acute setting in the same hospital directly into an ambulatory rehabilitation program of care.
A child may be discharged home from hospital in a different state, to commence an ambulatory rehabilitation program in their home state.

Children may be referred to an ambulatory program of rehabilitation from a range of sources, including General Practitioner or a community based therapist.

Codeset values:

1	Referred by General Practitioner
2	Referred by community based therapist
3	Referred by same hospital
4	Referred from another hospital – same state (AU) / DHB (NZ)
5	Referred from another hospital – different state (AU) / DHB (NZ)
6	Other

Is episode a continuation of recent inpatient care?

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: This item collects information about episodes which are a continuation of recent (i.e. within one week) inpatient rehabilitation care.

Justification: This item enables the continuum of a child's rehabilitation journey to be collected and analysed.

Guide for use: If the child received inpatient rehabilitation for the same impairment within the previous week record 'yes'.

Codeset values:

1	Yes
2	No

Is this the first direct care rehabilitation episode for this impairment?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

The item relates to the child's impairment not the particular facility.

"Direct care" is when the child is under the direct care of the rehabilitation physician or team, i.e. they hold medical governance over the child. An episode of direct care can be provided in the inpatient rehabilitation setting or ambulatory rehabilitation setting (e.g. outpatient and/or community).

The first direct care rehabilitation episode for this impairment aims to identify those children that have repeated rehabilitation admissions/discharges as subsequent episodes are typically quite different to primary episodes.

Subsequent direct rehabilitation episodes of care are more common in certain impairments such as brain injury, spinal cord injury and/or amputee, where the child often has multiple rehabilitation episodes across a variety of settings.

Justification:

This item attempts to differentiate the child's first direct care rehabilitation episode from subsequent episodes throughout the child's rehabilitation journey. It is important to accurately collect data about first direct care rehabilitation episodes as data relating to first episodes of care and subsequent episodes has an impact on outcome benchmarks.

Guide for use:

Example:

INPATIENT ONLY: A child who had a traumatic brain injury (TBI), has an episode of acute care and is then transferred to an inpatient rehabilitation program. This is the first direct episode of rehabilitation care they have received for their TBI — record 1=Yes.

AMBULATORY ONLY: A child is admitted directly to an ambulatory rehabilitation program following a mild TBI. This is the first direct episode of rehabilitation care they have received for their TBI — record 1=Yes.

AMBULATORY FOLLOWING INPATIENT: A child who had a TBI, was admitted previously for inpatient rehabilitation and is subsequently admitted for an ambulatory rehabilitation episode. The ambulatory rehabilitation episode is NOT their first direct rehabilitation episode for this impairment — record 2=No.

INPATIENT FOLLOWING INPATIENT AT ANOTHER FACILITY: A child admitted for inpatient rehabilitation for an amputation was admitted previously for an episode of direct inpatient rehabilitation care for this same impairment in a different hospital— record 2=No.

INPATIENT FOLLOWING INPATIENT: A child with transverse myelitis received their first direct episode of rehabilitation care on the inpatient rehabilitation ward. He was then discharged into the community where he received ongoing ambulatory rehabilitation care. After 6 months, he was discharged from ambulatory rehabilitation and 12 months later re-admitted for another boost of inpatient rehabilitation care relating to the original spinal cord dysfunction — record 2=No.

Codeset values:

1	Yes
2	No

Need for interpreter service?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: An interpreter service can be paid or unpaid and includes the use of family members for interpretation and may be required by the child and/or family.

Justification: Collection of this item will allow analysis of impact of a requirement for an interpreter on length of stay (LOS) and other outcomes.

Guide for use: Record whether an interpreter service is required for the child and/or family.

Codeset values:

1	Interpreter needed and used
2	Interpreter needed and not used
3	Interpreter not needed

Accommodation support prior

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The type of support the child and their family/carer was receiving with respect to their usual accommodation prior to the rehabilitation episode of care.

Justification: The type of accommodation support before and after rehabilitation are collected to reflect and compare what level of support the child required in their usual accommodation.

Guide for use: Record the level of accommodation support the child and their family/carer received prior to their current episode of rehabilitation care. The child's usual level of support prior to the rehabilitation episode of care will not necessarily be the level of support required after discharge e.g. the child may not have required or received any additional accommodation support prior to the admission but will be discharged to an alternative placement such as a foster home.

Note: Only use ‘in home support provided by family’ to indicate family support over and above normal family support for a child of that age.

Codeset values:

1	No prior accommodation support
2	Institutional setting
3	In home support provided by family
4	In home support provided by external agency
5	Alternative placement (including foster home)
8	Other

Community support prior to admission

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item identifies whether community support was received by the child and family/carer prior to the current inpatient or ambulatory admission. This includes both paid and/or unpaid community support(s) received.

Justification: The type of community support(s) required by the child and family/carer before and after rehabilitation can be compared as an indicator of the child's rehabilitation outcomes, and any change in the child's functional independence.

Guide for use: Record 1,"Yes" if there community support was received and 2, "No" if the child and family/carer have not been accessing any additional community support. If "Yes", complete the next question regarding the type of community support(s) received.

Codeset values:

1	Yes
2	No

Type of community support prior to admission

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

The level of community support that the child and family/carer received prior to the current inpatient or ambulatory admission. This includes both paid and/or unpaid community support(s) received.

Justification:

The type of community support(s) received before and after rehabilitation are collected to reflect and compare what level of support the child required in their usual accommodation and what additional support may be required after discharge from rehabilitation.

Guide for use:

Record the type(s) of community support received by the child and family/carer.

Therapy support for individuals: e.g. the child has received ongoing speech and language services to help address a developmental delay in communication skills.

Early childhood intervention: e.g. the child is under the care of an early intervention team based approach to help address global delays in development. This implies more than one discipline supporting the child and is often seen in preschool age children.

Specialist behavioural/mental health services: e.g. the child has been receiving specialist mental health services such as Child and Youth Mental Health, or a behavioural psychologist to support the child's functioning e.g. anxiety or behavioural concerns.

Counselling (individual/family/group): e.g. the child and/or the family have been receiving family therapy or counselling e.g. in relation to a divorce.

Case management and coordination: e.g. the child has received a previous compensation payout and the family have employed a case manager to help source and coordinate services.

Respite: the child receives respite services either in their own home or through a different accommodation venue e.g. the child stays with a different family one weekend/month.

Other Community support: If you record 'Yes' please comment regarding the type of community support received in the General comments field.

Data Items:

Therapy support for individuals

Early childhood intervention

Specialist behaviour/mental health services

Counselling (individual/family/group)

Case management and co-ordination

Respite

Other Community Support

Codeset values:

1	Yes
2	No

School/day care support prior to admission

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item identifies whether any support was being provided to the child in the educational setting prior to this impairment. This support is in addition to that offered in a typical classroom situation e.g. a child who receives additional support with reading from the teacher's aide as part of a small group, should not be included. However, a child who requires a full time teacher's aide to manage their behaviour within the typical classroom should be recorded as "yes".

Justification: The support required by a child to attend school/day care before and after rehabilitation can be compared as an indicator of any change in the child's functional independence after rehabilitation.

Guide for use: Record whether the child received support in the educational setting prior to this impairment.

Codeset values:

1	Yes
2	No
3	Child does not attend school/day care

Type of accommodation during day program

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: The type of accommodation in which the child resides during this episode of ambulatory rehabilitation.

Justification: The type of accommodation before, during and after rehabilitation treatment are collected to reflect and compare where the child has come from (their usual accommodation) and where they are going to end up (what will become their usual accommodation). Comparison of accommodation pre, during and post rehabilitation treatment is an indicator of rehabilitation outcomes.

Guide for use: If the child is residing in their usual accommodation (where the address before and during the rehabilitation episode are the same) during this ambulatory episode of care, only answer 6, “not in interim accommodation”.
If the child is residing in a “private residence” during this ambulatory episode of care, but the address is different to their usual accommodation, specify the reason for the change of address using the codeset values 1-5.

Within the code set:
- Interim accommodation due to geographical needs (may be private residence, hospital accommodation or hotel), relates to those children and families who may be required to stay with friends and/or family in order to get to the ambulatory rehabilitation service. This would include children and families who come from remote or isolated communities.

- Interim accommodation due to increased support needs (may be private residence, hospital accommodation or hotel), relates to those children who require increased assistance with ADL's because of their decreased functional ability post impairment e.g. external or internal stairs, that the child cannot yet manage.

Codeset values:

1	Interim accommodation due to geographical needs
2	Interim accommodation due to increased support needs
3	Interim accommodation due to change in pre-rehabilitation living arrangements required
4	Interim accommodation due to awaiting guardianship
5	Interim accommodation for other reason
6	Not in interim accommodation

Is there an existing comorbidity interfering with this episode?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

A comorbidity is defined as any other significant existing illness/impairments, which were not part of the principal presenting condition, and which were observed to interfere with the child's ability to participate in the rehabilitation program.

Justification:

It is important to identify whether the child had comorbidities, as investigation of such data may reflect a relationship between the presence of comorbidities, the rehabilitation outcome and length of stay.

Guide for use:

Only record 1, "Yes" if the child's rehabilitation program was affected by the comorbidity, otherwise answer 2, "No". The effect of the comorbidity should be apparent in the child's medical record.

Example:
A child required extensive medication management for diabetes and had variability in blood sugar levels during the admission that affected their ability to participate.
A child required a longer length of stay to accommodate severe failure to thrive.
A child had one or more epileptic fits that caused the child to need extra time to recover and be able to participate at the same level prior to the fit.

Do not leave blank. If a comorbidity is present and it has interfered with the child's rehabilitation, a suspension of treatment may also have occurred and would need to be recorded.

Codeset values:

1	Yes
2	No

Comorbidities interfering with rehabilitation episode

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item identifies which comorbidities interfered with the rehabilitation episode.

Justification: It is important to identify which comorbidities interfered with the rehabilitation episode, as investigation of such data may reflect a relationship between the comorbidity, the rehabilitation outcome and length of stay.

Guide for use: Only record comorbidities that have interfered with the rehabilitation episode. Up to four comorbidities can be entered from the code list.
Please carefully consider the use of the code '99 Other' as this contributes to non-specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.
If a comorbidity is present and it has interfered with the child's rehabilitation, it is highly likely a suspension of treatment may also have occurred and would need to be recorded.

Note: Only use 'Mental Health Issue' if there has been a formal diagnosis by a qualified practitioner.

Example:
If a child has ADHD and it is impacting their ability to participate in rehabilitation, code as 'behavioural conditions'. If a child is suffering from psychological trauma as a result of abuse, code as 'Other' and then comment in the General comments field.

Data Items:

Comorbidities interfering with rehabilitation episode 1

Comorbidities interfering with rehabilitation episode 2

Comorbidities interfering with rehabilitation episode 3

Comorbidities interfering with rehabilitation episode 4

Codeset values:

1	Cardiac conditions
2	Respiratory Conditions
3	Amputation
4	Congenital condition with intellectual impairment
5	Congenital condition with physical impairment
6	Acquired intellectual impairment
7	Acquired physical Impairment
8	Skin conditions
9	Visual impairment
10	Hearing impairment
11	Behavioural conditions
12	Mental health issues
13	Nutritional issues
14	Endocrine issues
15	Other

Were there any complications interfering with this episode?

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

A complication may be defined as a disease or disorder concurrent with the principal impairment (or exacerbation of impairment), arising during the rehabilitation episode and which prevents the child from engaging at the anticipated intensity in their planned rehabilitation program.

Justification:

It is important to identify whether the child had any complications, as investigation of such data may reflect a relationship between the presence of complications, the rehabilitation outcome and length of stay.

Guide for use:

Only record 1, “Yes” if the child's complication prevented them from engaging at the anticipated intensity in their planned rehabilitation program, otherwise answer 2, “No”. Report only those complications arising during the rehabilitation episode.

Example:
A child with a spinal cord injury developed a pressure injury which prevented them from engaging at the anticipated intensity in their planned rehabilitation program.
A child developed a UTI, became unwell and was unable to engage at the anticipated intensity in their planned rehabilitation program.

If a complication is present and it has interfered with the child's rehabilitation, it is likely a suspension of treatment may also have occurred and would need to be recorded.

Codeset values:

1	Yes
2	No

Complications interfering with rehabilitation episode

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Complications interfering with the rehabilitation episode (up to four can be selected).

Justification: It is important to identify which complications interfered with the rehabilitation episode, as investigation of such data may reflect a relationship between the complication, the rehabilitation outcome and length of stay.

Guide for use:
Only record complications that prevented the child from engaging at the anticipated intensity in their planned rehabilitation program.
Record up to four complications from the code list.
Please carefully consider the use of the code '99 Other' as this contributes to non-specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.
If a complication is present and it has prevented the child from engaging at the anticipated intensity in their planned rehabilitation program, it is highly likely a suspension of treatment may also have occurred and would need to be recorded.

Note: If a child develops anxiety/depression during the course of their rehabilitation episode which impacts them from participating in their rehabilitation program, choose ‘Other’, and then record a specific comment in the General comments field.

Data Items:

Complications interfering with rehabilitation episode 1

Complications interfering with rehabilitation episode 2

Complications interfering with rehabilitation episode 3

Complications interfering with rehabilitation episode 4

Codeset values:

1	UTI
2	Pressure injury
3	Wound infection
4	Infection other than wound/UTI (Including gastroenteritis, respiratory, otitis media, chicken pox)
5	Neurosurgical complications
6	Neurological complications
7	Orthopaedic complications (Including fracture, HO, osteomyelitis)
8	DVT
9	Other

Date multidisciplinary team rehabilitation plan established

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: A multidisciplinary team rehabilitation plan comprises a series of documented and agreed initiatives/treatment (specifying program goals and time frames), which has been established through multidisciplinary consultation and consultation with the child and their family/carer.

Justification: The establishment of a multidisciplinary team rehabilitation plan with regular review is necessary for effective child rehabilitation. This item reflects timely establishment of a multidisciplinary team rehabilitation plan.

Guide for use: Record the date the multidisciplinary team rehabilitation plan is formally documented in the child's medical record. It must be a record of the plan formulated by the team on initial assessment of the child. Often, the initial case conference document is a formal multidisciplinary plan for the child's care while participating in rehabilitation. In other cases, the child may be assessed by a multidisciplinary team prior to commencing a rehabilitation program, and the plan formulated from this assessment may form the multidisciplinary rehabilitation plan.

WeeFIM start date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date that the child's admission WeeFIM was completed.
Justification:	This item reflects timely assessment of function on admission. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.
Guide for use:	Admission WeeFIM scoring needs to be completed as soon as possible after admission to establish an appropriate baseline functional score. Assessment is complete when the last item of the WeeFIM assessment is completed and the date recorded here is the date on which this occurs.

WeeFIM admission scores

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The child's WeeFIM score for each of the 18 WeeFIM items, assessed at the time of admission.

Justification: The WeeFIM score is a basic indication of severity of disability. The WeeFIM is used to track changes in the child's function during rehabilitation. Functional change is a key outcome measure of rehabilitation episodes. The AROC paediatric dataset collects WeeFIM scores at episode start and end. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.

Guide for use: Record the child's WeeFIM score for each of the 18 WeeFIM items, assessed at the time of admission. WeeFIM admission scoring needs to be completed as soon as possible after admission to establish an appropriate baseline functional score.

Data Items:

WeeFIM admission score for eating

WeeFIM admission score for grooming

WeeFIM admission score for bathing

WeeFIM admission score for dressing upper body

WeeFIM admission score for dressing lower body

WeeFIM admission score for toileting

WeeFIM admission score for bladder management

WeeFIM admission score for bowel management

WeeFIM admission score for transfer to bed/chair/wheelchair

WeeFIM admission score for transfer to toilet

WeeFIM admission score for transfer to shower/tub

WeeFIM admission score for locomotion

WeeFIM admission score for stairs

WeeFIM admission score for comprehension

WeeFIM admission score for expression

WeeFIM admission score for social interaction

WeeFIM admission score for problem solving

WeeFIM admission score for memory

Codeset values:

1	Total contact assistance
2	Maximal contact assistance
3	Moderate contact assistance
4	Minimal contact assistance
5	Supervision or setup
6	Modified independence
7	Complete independence

WeeFIM end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date that the child's discharge WeeFIM was completed.
Justification:	This item reflects timely assessment of function on discharge. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.
Guide for use:	Discharge WeeFIM scoring needs to be completed before the child is discharged from the rehabilitation program. The score should reflect the functional status of the child at discharge. Assessment is complete when the last item of the WeeFIM assessment is completed and the date recorded here is the date on which this occurs.

WeeFIM discharge scores

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Record the child's WeeFIM score for each of the 18 WeeFIM items, assessed at the time of discharge.

Justification: The WeeFIM score is a basic indication of severity of disability. The WeeFIM is used to track changes in the child's function during rehabilitation. Functional change is a key outcome measure of rehabilitation episodes. The AROC paediatric dataset collects WeeFIM scores at episode start and end. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.

Guide for use: WeeFIM discharge scoring needs to be completed before the child is discharged from the rehabilitation program. The score should reflect the functional status of the child at discharge.

Data Items:

WeeFIM discharge score for eating

WeeFIM discharge score for grooming

WeeFIM discharge score for bathing

WeeFIM discharge score for dressing upper body

WeeFIM discharge score for dressing lower body

WeeFIM discharge score for toileting

WeeFIM discharge score for bladder management

WeeFIM discharge score for bowel management

WeeFIM discharge score for transfer to bed/chair/wheelchair

WeeFIM discharge score for transfer to toilet

WeeFIM discharge score for transfer to shower/tub

WeeFIM discharge score for locomotion

WeeFIM discharge score for stairs

WeeFIM discharge score for comprehension

WeeFIM discharge score for expression

WeeFIM discharge score for social interaction

WeeFIM discharge score for problem solving

WeeFIM discharge score for memory

Codeset values:

1	Total contact assistance
2	Maximal contact assistance
3	Moderate contact assistance
4	Minimal contact assistance
5	Supervision or setup
6	Modified independence
7	Complete independence

COPM start date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date the Canadian Occupational Performance Measure (COPM) was administered at episode start.
Justification:	The COPM is an individualised, client-centred outcome measure. The COPM is an evidence-based outcome measure designed to capture a client's (child's and/or family's) perception of performance in everyday living, over time. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection.
Guide for use:	Record the date the initial COPM was administered.

COPM issue descriptions

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Canadian Occupational Performance Measure (COPM) measures daily activities identified by the child/family as difficult to achieve.

Justification: The COPM is an individualised, client-centred outcome measure. The COPM is an evidence-based outcome measure designed to capture a client's (child's and/or family's) perception of performance in everyday living, over time. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection.

Guide for use: In collaboration with the child and family identify the daily activities in self-care, productivity and leisure which are difficult to achieve. Self-care activities include personal care, functional mobility and community management. Productivity includes play skills and homework. Leisure includes sports, outings and travel.
Record the most important problems, as identified by the child and/or family (maximum 5).

Data Items:

COPM issue 1

COPM issue 2

COPM issue 3

COPM issue 4

COPM issue 5

COPM start issue performance and satisfaction

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

For each issue identified (maximum 5) record the child/family's perception of performance and the satisfaction, at the initial assessment COPM.

Use a 10 point scale where:

For performance;
1 = Poor performance, and
10 = Very good performance.

For Satisfaction;
1 = Low satisfaction, and
10 = High satisfaction.

Justification:

The COPM is an individualised, client-centred outcome measure. The COPM is an evidence-based outcome measure designed to capture a client's (child's and/or family's) perception of performance in everyday living, over time. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection.

Guide for use:

Using score card (marked 1-10) ask the child/family to rate performance and satisfaction for each issue.

Data Items:

COPM start issue 1 performance
COPM start issue 1 satisfaction
COPM start issue 2 performance
COPM start issue 2 satisfaction
COPM start issue 3 performance
COPM start issue 3 satisfaction
COPM start issue 4 performance
COPM start issue 4 satisfaction
COPM start issue 5 performance
COPM start issue 5 satisfaction

Codeset values:

1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10

COPM end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date the Canadian Occupational Performance Measure (COPM) was administered at episode end.
Justification:	The COPM is an individualised, client-centred outcome measure. The COPM is an evidence-based outcome measure designed to capture a client's (child's and/or family's) perception of performance in everyday living, over time. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection.
Guide for use:	Record the date the final COPM was administered.

COPM end issue performance and satisfaction

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

For each issue identified (maximum 5) record the child/family's perception of performance and the satisfaction, at the final assessment COPM.

Use a 10 point scale where:

For performance;
1 = Poor performance, and
10 = Very good performance.

For Satisfaction;
1 = Low satisfaction, and
10 = High satisfaction.

Justification:

The COPM is an individualised, client-centred outcome measure. The COPM is an evidence-based outcome measure designed to capture a client's (child's and/or family's) perception of performance in everyday living, over time. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection.

Guide for use:

Using score card (marked 1-10) ask the child/family to rate performance and satisfaction for each issue.

Data Items:

COPM end issue 1 performance
COPM end issue 1 satisfaction
COPM end issue 2 performance
COPM end issue 2 satisfaction
COPM end issue 3 performance
COPM end issue 3 satisfaction
COPM end issue 4 performance
COPM end issue 4 satisfaction
COPM end issue 5 performance
COPM end issue 5 satisfaction

Codeset values:

1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10	10

FMS start date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date on which the Functional Mobility Scale (FMS) assessment was scored at episode start.
Justification:	This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.
Guide for use:	Record the date on which the FMS was scored at episode start.

FMS score episode start - distance 5 metres

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Functional Mobility Scale (FMS) score for walking distance - 5 metres at episode start, which best describes the child's current function.

Justification: This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.

Guide for use: The FMS rates walking ability at 3 specific distances (5, 50 and 500 metres). This represents the child's mobility in the home, school and community settings and accounts for different assistive devices used by the same child in different environments. The clinician makes the assessment on the basis of questions asked of the child/parent. The FMS is a performance measure and should be used to rate what the child actually does at this point in time, not what they could do or used to be able to do.

Select the number (from 1-6) which best describes current function.

Codeset values:

1	1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2	2 - Uses a walker or frame, without help from another person.
3	3 - Uses crutches, without help from another person.
4	4 - Uses sticks (one or two), without help from another person.
5	5 - Independent on level surfaces, does not use walking aids or need help from another person. Requires a rail for stairs. Note: If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate rating.
6	6 - Independent on all surfaces, does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc and in a crowded environment.
7	Crawling - Child crawls for mobility at home
8	None - Does not apply, for example the child does not complete the distance

FMS score episode start - walking distance 50 metres

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Functional Mobility Scale (FMS) score for walking distance - 50 metres at episode start, which best describes the child's current function.

Justification: This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.

Guide for use: The FMS rates walking ability at 3 specific distances (5, 50 and 500 metres). This represents the child's mobility in the home, school and community settings and accounts for different assistive devices used by the same child in different environments. The clinician makes the assessment on the basis of questions asked of the child/parent. The FMS is a performance measure and should be used to rate what the child actually does at this point in time, not what they could do or used to be able to do.

Select the number (from 1-6) which best describes current function.

Codeset values:

1	1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2	2 - Uses a walker or frame, without help from another person.
3	3 - Uses crutches, without help from another person.
4	4 - Uses sticks (one or two), without help from another person.
5	5 - Independent on level surfaces, does not use walking aids or need help from another person. Requires a rail for stairs. Note: If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate rating.
6	6 - Independent on all surfaces, does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc and in a crowded environment.
8	None - Does not apply, for example the child does not complete the distance.

FMS score episode start - walking distance 500 metres

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Functional Mobility Scale (FMS) score for walking distance - 500 metres at episode start, which best describes the child's current function.

Justification: This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.

Guide for use: The FMS rates walking ability at 3 specific distances (5, 50 and 500 metres). This represents the child's mobility in the home, school and community settings and accounts for different assistive devices used by the same child in different environments. The clinician makes the assessment on the basis of questions asked of the child/parent. The FMS is a performance measure and should be used to rate what the child actually does at this point in time, not what they could do or used to be able to do.

Select the number (from 1-6) which best describes current function.

Codeset values:

1	1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2	2 - Uses a walker or frame, without help from another person.
3	3 - Uses crutches, without help from another person.
4	4 - Uses sticks (one or two), without help from another person.
5	5 - Independent on level surfaces, does not use walking aids or need help from another person. Requires a rail for stairs. Note: If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate rating.
6	6 - Independent on all surfaces, does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc and in a crowded environment.
8	None - Does not apply, for example the child does not complete the distance.

FMS end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The date on which the Functional Mobility Scale (FMS) assessment was scored at episode end.
Justification:	This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.
Guide for use:	Record the date on which the FMS was scored at episode end.

FMS score episode end - walking distance 5 metres

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Functional Mobility Scale (FMS) score for walking distance - 5 metres at episode end, which best describes the child's current function.

Justification: This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.

Guide for use: The FMS rates walking ability at 3 specific distances (5, 50 and 500 metres). This represents the child's mobility in the home, school and community settings and accounts for different assistive devices used by the same child in different environments. The clinician makes the assessment on the basis of questions asked of the child/parent. The FMS is a performance measure and should be used to rate what the child actually does at this point in time, not what they could do or used to be able to do.

Select the number (from 1-6) which best describes current function.

Codeset values:

1	1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2	2 - Uses a walker or frame, without help from another person.
3	3 - Uses crutches, without help from another person.
4	4 - Uses sticks (one or two), without help from another person.
5	5 - Independent on level surfaces, does not use walking aids or need help from another person. Requires a rail for stairs. Note: If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate rating.
6	6 - Independent on all surfaces, does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc and in a crowded environment.
7	Crawling - Child crawls for mobility at home
8	None - Does not apply, for example the child does not complete the distance

FMS score episode end - walking distance 50 metres

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Functional Mobility Scale (FMS) score for walking distance - 50 metres at episode end, which best describes the child's current function.

Justification: This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.

Guide for use: The FMS rates walking ability at 3 specific distances (5, 50 and 500 metres). This represents the child's mobility in the home, school and community settings and accounts for different assistive devices used by the same child in different environments. The clinician makes the assessment on the basis of questions asked of the child/parent. The FMS is a performance measure and should be used to rate what the child actually does at this point in time, not what they could do or used to be able to do.

Select the number (from 1-6) which best describes current function.

Codeset values:

1	1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2	2 - Uses a walker or frame, without help from another person.
3	3 - Uses crutches, without help from another person.
4	4 - Uses sticks (one or two), without help from another person.
5	5 - Independent on level surfaces, does not use walking aids or need help from another person. Requires a rail for stairs. Note: If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate rating.
6	6 - Independent on all surfaces, does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc and in a crowded environment.
8	None - Does not apply, for example the child does not complete the distance.

FMS score episode end - walking distance 500 metres

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The Functional Mobility Scale (FMS) score for walking distance - 500 metres at episode end, which best describes the child's current function.

Justification: This is an optional item that reflects assessment of functional mobility for children with a variety of physical impairments.

Guide for use: The FMS rates walking ability at 3 specific distances (5, 50 and 500 metres). This represents the child's mobility in the home, school and community settings and accounts for different assistive devices used by the same child in different environments. The clinician makes the assessment on the basis of questions asked of the child/parent. The FMS is a performance measure and should be used to rate what the child actually does at this point in time, not what they could do or used to be able to do.

Select the number (from 1-6) which best describes current function.

Codeset values:

1	1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.
2	2 - Uses a walker or frame, without help from another person.
3	3 - Uses crutches, without help from another person.
4	4 - Uses sticks (one or two), without help from another person.
5	5 - Independent on level surfaces, does not use walking aids or need help from another person. Requires a rail for stairs. Note: If uses furniture, walls, fences, shop fronts for support, please use 4 as the appropriate rating.
6	6 - Independent on all surfaces, does not use any walking aids or need any help from another person when walking over all surfaces including uneven ground, curbs etc and in a crowded environment.
8	None - Does not apply, for example the child does not complete the distance.

PEDI start date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The date the initial Paediatric Evaluation of Disability Inventory (PEDI) was administered.

Justification: The PEDI is a measure by observation of a child's current functional performance and can be used to track changes over time.

The PEDI measures both capability and performance of functional activities on three content domains:
- self care
- mobility
- social function

This is an optional item.

Guide for use: Record the date the initial PEDI was administered.

PEDI start self care total

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The Paediatric Evaluation of Disability Inventory (PEDI) self care domain total score at episode start.
Justification:	This is an optional item which can be used to measure a child's current performance on functional activities in the self care domain.
Guide for use:	Record the PEDI self care domain total score. Please ensure that all self care domain items have been answered before the total is calculated.

PEDI start mobility total

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The Paediatric Evaluation of Disability Inventory (PEDI) mobility domain total score at episode start.
Justification:	This is an optional item which can be used to measure a child's current performance on functional activities in the mobility domain.
Guide for use:	Record the PEDI mobility domain total score. Please ensure that all mobility domain items have been answered before the total is calculated.

PEDI start social function total

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The Paediatric Evaluation of Disability Inventory (PEDI) social function domain total score at episode start.
Justification:	This is an optional item which can be used to measure a child's current performance on functional activities in the social function domain.
Guide for use:	Record the PEDI social function domain total score. Please ensure that all social function domain items have been answered before the total is calculated.

PEDI start self care: Caregiver assistance

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) caregiver assistance for self care activities at episode start.

Justification: This is an optional item which can be used to measure the current caregiver assistance required for self care activities.

Guide for use: Record the caregiver assistance provided for self care activities at episode start.

Data Items:

PEDI start self care eating score

PEDI start self care grooming score

PEDI start self care bathing score

PEDI start self care dressing upper body score

PEDI start self care dressing lower body score

PEDI start self care toileting score

PEDI start self care bladder management score

PEDI start self care bowel management score

Codeset values:

0	0 - Total assistance
1	1 - Maximal
2	2 - Moderate
3	3 - Minimal
4	4 - Supervision
5	5 - Independent

PEDI start self care: Modification

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) modification to self care activities at episode start.

Justification: This is an optional item which can be used to measure the current modification required for self care.

Guide for use: Record the self care modification, that is, None/Child/Rehab/Extensive, for each PEDI self care domain item.

Data Items:

PEDI start self care eating NCRE

PEDI start self care grooming NCRE

PEDI start self care bathing NCRE

PEDI start self care dressing upper body NCRE

PEDI start self care dressing lower body NCRE

PEDI start self care toileting NCRE

PEDI start self care bladder management NCRE

PEDI start self care bowel management NCRE

Codeset values:

1	None
2	Child
3	Rehab
4	Extensive

PEDI start mobility: Caregiver assistance

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation Disability of Inventory (PEDI) caregiver assistance for mobility activities at episode start.

Justification: This is an optional item which can be used to measure the current caregiver assistance required for mobility activities.

Guide for use: Record the caregiver assistance provided for mobility activities at episode start.

Data Items:

PEDI start mobility chair/toilet score

PEDI start mobility car transfers score

PEDI start mobility bed mobility/transfers score

PEDI start mobility tub transfers score

PEDI start mobility Indoor locomotion score

PEDI start mobility outdoor locomotion score

PEDI start mobility stairs score

Codeset values:

0	0 - Total assistance
1	1 - Maximal
2	2 - Moderate
3	3 - Minimal
4	4 - Supervision
5	5 - Independent

PEDI start mobility: Modification

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability of Inventory (PEDI) modification to mobility activities at episode start.

Justification: This is an optional item which can be used to measure the current modification required for mobility activities.

Guide for use: Record the mobility modification, that is, None/Child/Rehab/Extensive, for each PEDI mobility domain item.

Data Items:

PEDI start mobility chair/toilet NCRE

PEDI start mobility car transfers NCRE

PEDI start mobility bed mobility/transfers NCRE

PEDI start mobility tub transfers NCRE

PEDI start mobility indoor locomotion NCRE

PEDI start mobility outdoor locomotion NCRE

PEDI start mobility stairs NCRE

Codeset values:

1	None
2	Child
3	Rehab
4	Extensive

PEDI start social function: Caregiver assistance

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation Disability of Inventory (PEDI) caregiver assistance for social function activities at episode start.

Justification: This is an optional item which can be used to measure the current caregiver assistance required for social function activities.

Guide for use: Record the caregiver assistance provided for social function activities at episode start.

Data Items:

PEDI start social function functional comprehension score

PEDI start social function functional expression score

PEDI start social function joint problem solving score

PEDI start social function peer play score

PEDI start social function safety score

Codeset values:

0	0 - Total assistance
1	1 - Maximal
2	2 - Moderate
3	3 - Minimal
4	4 - Supervision
5	5 - Independent

PEDI start social function: Modification

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) modification to social function activities at episode start.

Justification: This is an optional item which can be used to measure the current modification required for social function activities.

Guide for use: Record the social function modification, that is, None/Child/Rehab/Extensive, for each PEDI social function domain item.

Data Items:

PEDI start social function functional comprehension NCRE

PEDI start social function functional expression NCRE

PEDI start social function joint problem NCRE

PEDI start social function peer play NCRE

PEDI start social function safety NCRE

Codeset values:

1	None
2	Child
3	Rehab
4	Extensive

PEDI end date

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The date the Paediatric Evaluation of Disability Inventory (PEDI) was administered at episode end.

Justification: The PEDI is a measure by observation of a child's current functional performance and can be used to track changes over time.

The PEDI measures both capability and performance of functional activities on three content domains:
- self care
- mobility
- social function

This is an optional item.

Guide for use: Record the date the final PEDI was administered.

PEDI end self care total

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The Paediatric Evaluation of Disability Inventory (PEDI) self care domain total score at episode end.
Justification:	This is an optional item which can be used to measure a child's current performance on functional activities in the self care domain.
Guide for use:	Record the PEDI self care domain total score. Please ensure that all self care domain items have been answered before the total is calculated.

PEDI end mobility total

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The Paediatric Evaluation of Disability Inventory (PEDI) mobility domain total score at episode end.
Justification:	This is an optional item which can be used to measure a child's current performance on functional activities in the mobility domain.
Guide for use:	Record the PEDI mobility domain total score. Please ensure that all mobility domain items have been answered before the total is calculated.

PEDI end social function total

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:	The Paediatric Evaluation of Disability Inventory (PEDI) social function domain total score at episode end.
Justification:	This is an optional item which can be used to measure a child's current performance on functional activities in the social function domain.
Guide for use:	Record the PEDI social function domain total score. Please ensure that all social function domain items have been answered before the total is calculated.

PEDI end self care: Caregiver assistance

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) caregiver assistance for self care activities at episode end.

Justification: This is an optional item which can be used to measure the current caregiver assistance required for mobility activities.

Guide for use: Record the caregiver assistance provided for self care activities at episode end.

Data Items:

PEDI end self care eating score

PEDI end self care grooming score

PEDI end self care bathing score

PEDI end self care dressing upper body score

PEDI end self care dressing lower body score

PEDI end self care toileting score

PEDI end self care bladder management score

PEDI end self care bowel management score

Codeset values:

0	0 - Total assistance
1	1 - Maximal
2	2 - Moderate
3	3 - Minimal
4	4 - Supervision
5	5 - Independent

PEDI end self care: Modification

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) modification to self care activities at episode end.

Justification: This is an optional item which can be used to measure the current modification required for self care activities.

Guide for use: Record the self care modification, that is, None/Child/Rehab/Extensive, for each PEDI self care domain item.

Data Items:

PEDI end self care eating NCRE

PEDI end self care grooming NCRE

PEDI end self care bathing NCRE

PEDI end self care dressing upper body NCRE

PEDI end self care dressing lower body NCRE

PEDI end self care toileting NCRE

PEDI end self care bladder management NCRE

PEDI end self care bowel management NCRE

Codeset values:

1	None
2	Child
3	Rehab
4	Extensive

PEDI end mobility: Caregiver assistance

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: PEDI caregiver assistance for mobility activities at episode end.

Justification: This is an optional item which can be used to measure the current caregiver assistance required for mobility activities.

Guide for use: Record the caregiver assistance provided for mobility activities at episode end.

Data Items:

PEDI end mobility chair/toilet score

PEDI end mobility car transfers score

PEDI end mobility bed mobility/transfers score

PEDI end mobility tub transfers score

PEDI end mobility indoor locomotion score

PEDI end mobility outdoor locomotion score

PEDI end mobility stairs score

Codeset values:

0	0 - Total assistance
1	1 - Maximal
2	2 - Moderate
3	3 - Minimal
4	4 - Supervision
5	5 - Independent

PEDI end mobility: Modification

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) modification to mobility activities at episode end.

Justification: This is an optional item which can be used to measure the current modification required for mobility activities.

Guide for use: Record the mobility modification, that is, None/Child/Rehab/Extensive, for each PEDI mobility domain item.

Data Items:

PEDI end mobility chair/toilet NCRE

PEDI end mobility car transfers NCRE

PEDI end mobility bed mobility/transfers NCRE

PEDI end mobility tub transfers NCRE

PEDI end mobility indoor locomotion NCRE

PEDI end mobility outdoor locomotion NCRE

PEDI end mobility stairs NCRE

Codeset values:

1	None
2	Child
3	Rehab
4	Extensive

PEDI end social function: Caregiver assistance

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation Disability of Inventory (PEDI) caregiver assistance for social function activities at episode end.

Justification: This is an optional item which can be used to measure the current caregiver assistance required for social function activities.

Guide for use: Record the caregiver assistance provided for social function activities at episode end.

Data Items:

PEDI end social function functional comprehension score

PEDI end social function functional expression score

PEDI end social function joint problem solving score

PEDI end social function peer play score

PEDI end social function safety score

Codeset values:

0	0 - Total assistance
1	1 - Maximal
2	2 - Moderate
3	3 - Minimal
4	4 - Supervision
5	5 - Independent

PEDI end social function: Modification

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Paediatric Evaluation of Disability Inventory (PEDI) modification to social function activities at episode end.

Justification: This is an optional item which can be used to measure the current modification required for social function activities.

Guide for use: Record the social function modification, that is, None/Child/Rehab/Extensive, for each PEDI social function domain item.

Data Items:

PEDI end social function functional comprehension NCRE

PEDI end social function functional expression NCRE

PEDI end social function joint problem solving NCRE

PEDI end social function peer play NCRE

PEDI end social function safety NCRE

Codeset values:

1	None
2	Child
3	Rehab
4	Extensive

Was a home visit, initiated by your service, completed?

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: A home visit may be defined as a therapy/nursing visit to the child's family residence to identify potential factors impacting on discharge e.g. major or minor modifications that may be required. This visit may be completed by the treating service or undertaken by an alternate service at the request of the treating team.

Justification: It is important to identify whether a home visit was completed as investigation of this data may contribute to an understanding of the severity of injury/impairment and the complexity of care needs.

Guide for use: Record whether a home visit to the child's home was completed.

Codeset values:

1	Yes
2	No
9	Unknown

Home visit date

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: The date that a home visit initiated by your service was completed.

Justification: This item allows for the analysis of the time between home visit and episode start and/or end.

Guide for use: Record the date that a home visit to the child's home was completed. Record the date that the actual visit was completed and not the date that it was requested if an alternate service completed this.

Note: If multiple visits were performed, for the AROC data collection record the date of the first visit only.

Was a school or daycare visit, initiated by your service, completed?

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: A school or daycare visit may be defined as a therapy/nursing visit to the child's school or daycare to identify potential factors impacting on the child's return to school or daycare e.g. major or minor modifications that may be required. This visit may be completed by the treating service or undertaken by an alternate service on the request of the treating team. This may also be completed via a telehealth link up.

Justification: It is important to identify whether a school or day care visit was completed as investigation of this data may contribute to an understanding of the severity of injury/impairment and the complexity of care needs.

Guide for use: Record whether a visit to the child's school or daycare was completed.

Codeset values:

1	Yes
2	No
9	Unknown

School visit date

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: The date that a school/day care visit was completed.

Justification: This item allows for the analysis of the time between school visit and episode start and/or end.

Guide for use: Record the date that a school visit to the child's school or daycare was completed. Record the date that the actual visit was completed and not the date that it was requested if an alternate service completed this.

Note: If multiple visits were performed, for the AROC data collection record the date of the first visit only.

Total number of leave days

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition:

Leave days are a temporary absence from hospital, with medical approval, for a period no greater than seven consecutive days.

A leave day must be over a midnight period, i.e. ‘day leave’ without staying away from the hospital overnight is not counted as a ‘leave day’.

Justification:

Recording of leave days allows for the exclusion of these days from AROC's calculation of length of stay.

Guide for use:

Enter the number of leave days that occurred during the episode (if there were none enter 0).

Example:
Maddie is nearing the end of her rehabilitation episode. It has been decided that Maddie will go home for two days and nights, on trial leave. Maddie and her family cope quite well, Maddie returns to the hospital, finishes her rehabilitation program and is then discharged.
Total leave days = 2.

If there are a number of leave periods, calculate the total leave days by the sum of the length of leave (date returned from leave minus date went on leave) for all periods during the child’s rehabilitation episode.

Example:
A month before discharge, Ebony trialed an overnight stay at her own home. It was successful, so she spent 2 days over each weekend with her family at home for the remaining 3 weeks of her rehabilitation episode.
Total leave days = 1+2+2+2= 7 days.

Total number of suspension days

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition:

The sum of the number of days rehabilitation treatment was suspended for a medical reason during an episode of rehabilitation.

Justification:

Achievement of a child's rehabilitation goals may be dependent upon the consistency of treatment. Any requirement to suspend rehabilitation treatment may significantly impact upon treatment outcomes and the efficiency with which these can be achieved. Collection of this data item will provide facilities with information that they can use to help explain their outcomes to interested parties.

Guide for use:

There may be a number of reasons for the suspension of a rehabilitation program, for example:

1. A medical condition that prevents the child participating in their rehabilitation program. For example, a respiratory illness where the child has fevers and is unwell and therefore cannot participate in their rehabilitation program for a period of time. During the period of suspension the child may remain on the rehabilitation ward, or may need to be transferred to an acute ward for treatment.
2. The requirement for a medical procedure (e.g. CT / MRI) that prevents the child participating in their rehabilitation program for a period of time. The child may need to be transferred to another facility for this procedure.
3. The requirement for the child to attend a medical appointment that prevents the child participating in their rehabilitation program for a period of time e.g. attending a medical specialist review at a different hospital.

Enter the number of days that the child's treatment was suspended. If there were none enter '0'.

The general rule is that if a child's rehabilitation treatment is suspended for a period, and the child then comes back onto the same program of rehabilitation (that is, a new program with new goals is not required to be developed) the period of absence is counted as a suspension. It does not matter how long the period of suspension of treatment is, as long as the child comes back onto the same program of rehabilitation.

If a child's rehabilitation treatment is suspended for a period, but on their return to rehabilitation it is necessary to develop a new rehabilitation program (due to a change in the child's functional status or to the objectives of the rehabilitation program), then the period of absence is not counted as a suspension. Rather the child should be discharged (from the date their rehabilitation treatment was suspended) and a new episode commenced (from the date they return to rehabilitation).

Example:
Zac is admitted on Monday and commences treatment straight away. On Thursday he has a CT scan and he is unable to undertake his rehabilitation program on Thursday and Friday. He starts again on Monday. The following Wednesday he has a CT scan and he does not have rehabilitation treatment on Wednesday, but starts again on Thursday. Zac has had a total of 3 treatment suspension days.

Please note that if a child participates in their rehabilitation program in the morning and then has, for example, a CT scan in the afternoon, this is not a suspension of treatment, because the child has participated in their program on that day.

Please note that if a child refuses to participate in their rehabilitation program for a period of time, this is not considered a suspension of treatment.

Total number of suspension occurrences

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: The total number of rehabilitation treatment suspension occurrences during this admission.

Justification: Achievement of a child's rehabilitation goals may be dependent upon the consistency of treatment. The number of treatment suspensions occurrences as well as the total number of suspension days may significantly impact upon treatment outcomes and the efficiency with which these can be achieved. Collection of this data item will provide facilities with information that they can use to help explain their outcomes to interested parties.

Guide for use: Enter the number of periods of rehabilitation treatment suspensions that occurred during the episode. If there were none, enter 0.

Example:
Zac is admitted on Monday and commences treatment straight away. On Thursday he has a CT scan and he is unable to undertake his rehabilitation program on Thursday and Friday. He starts again on Monday. The following Wednesday he has a CT scan and he does not have rehabilitation treatment on Wednesday, but starts again on Thursday. Zac has had 2 occurrences of treatment suspensions.

Total number of days seen

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: The total number of days that therapy was provided to the child during their episode of care.

Justification: This item enables an accurate count of the total number of actual days the child received therapy during their rehabilitation episode of care, which may impact on patient outcomes. In the ambulatory setting, rehabilitation days are not necessarily continuous. A patient may attend therapy sessions 2 or 3 times a week for a number of weeks, thus the count of days between episode start and episode end may (and is usually) many more days than the count of actual number of days that therapy was provided to the child.

Guide for use: In the ambulatory setting, this should total all days that therapy was provided to the child. For example, if the child participated in the rehabilitation program 2 x per week for 4 weeks, the total number of days seen would be 8 days.

Total number of occasions of service

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition:	An occasion of service may be defined as “each time therapy is provided to the child”. One therapy provider may provide an occasion of service to one or many patients at the same time (individual vs. group therapy). A child may receive a number of occasions of service on the same day (e.g: physiotherapy in the morning and speech pathology in the afternoon). Occasions of service only include face-to-face service provision with the child/family present, inclusive of telehealth sessions with the child and family which replace attendance at the rehabilitation facility.
Justification:	This item is recorded to enable an accurate count of the number of occasions of service during the episode of care as number of occasions of services may impact on patient outcomes.
Guide for use:	Record the total number of occasions of service to the child. In the ambulatory setting, this should be the total of all occasions of service(s) that were provided to the child during the rehabilitation episode. For example, if the child attended the rehabilitation centre 2 x a week for 4 weeks, and had physiotherapy and occupational therapy at each visit the total number of occasions of service would be 16.

Disciplines involved in therapy

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: The type(s) of health professional or other care provider(s) who provided treatment/services to the child during their rehabilitation episode of care.

Justification: This item is required to identify inputs (therapy type) and their impact on functional outcomes.

Guide for use: Please indicate all types of therapy providers who provided treatment to the child during this episode of care. Choose up to 10.

Note: for therapies not listed, e.g. ‘art therapy’ and ‘animal therapy’ choose ‘Other’, and then comment in the General comments field.

Data Items:

Discipline involved in therapy 1
Discipline involved in therapy 2
Discipline involved in therapy 3
Discipline involved in therapy 4
Discipline involved in therapy 5
Discipline involved in therapy 6
Discipline involved in therapy 7
Discipline involved in therapy 8
Discipline involved in therapy 9
Discipline involved in therapy 10

Codeset values:

1	Care coordinator
2	Occupational therapist
3	Physiotherapist
4	Rehabilitation specialist
5	Paediatrician
6	Neuropsychologist
7	Social worker
8	Speech pathologist/therapist
9	Exercise physiologist
10	Allied health assistant
11	Nurse
12	Clinical psychologist
13	Neurologist
14	Registrar
15	Teacher
16	Dietician/nutritionist
17	Orthotist/Prosthetist
18	Paediatric Surgeon
19	Music therapist
20	Play / early life therapist
21	Other

Teams involved in Day Program

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: This item collects information regarding other teams involved in the child's day therapy program.

Justification: This allows analysis of the involvement of other teams additional to the rehabilitation team.

Guide for use: Record whether any other teams provided input into management for the child and family during their ambulatory rehabilitation episode.

Data Items:

Team involved in Day Program - Mental Health

Team involved in Day Program - School

Team involved in Day Program - Community Therapy

Team involved in Day Program - Other Hospital Teams

Codeset values:

1	Yes
2	No

Community ready date

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition:

A child is ready for discharge to the community when the treating multidisciplinary team determines:

- There are no further rehabilitation goals that require inpatient rehabilitation and any ongoing rehabilitation needs can be adequately met by services available outside the inpatient setting
- The child has achieved a level of function that allows them to be safely discharged to the community
- The child is medically stable (including comorbidities) and can be managed in the community by a GP
- The reason the child is still in inpatient rehabilitation care is beyond the control of the rehab team. For example, awaiting the outcome of an NDIS application or home modifications to be completed.

Justification:

This item is collected to identify episodes that experienced a delay between being ready for discharge to the community and actually being discharged from rehabilitation. This enables analysis of these two time points and the effect on outcomes especially length of stay (LOS).

Guide for use:

Record the date the child was deemed ready for discharge to the community from rehabilitation, not the date the child was actually discharged. In some cases, these dates may vary due to a delay.

Was there a delay in discharge?

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item identifies whether there was a delay in discharge, i.e. the child was clinically ready for discharge from inpatient rehabilitation but was actually discharged at a later date.

Justification: This item is collected to flag episodes that experienced a delay in their discharge.

Guide for use: Record 1,“Yes” if there was a delay and 2, “No” if there was not. If “Yes”, complete the next 9 questions about reason(s) for delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Awaiting home modification

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about home modifications that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed due to waiting for home modifications to be completed.

Guide for use: Example:

The child is unable to be discharged to his usual accommodation due to delays with major or minor home modifications e.g. The family is awaiting necessary changes to the bathroom or construction of a ramp.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Unresolved legal issues

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about unresolved legal issues that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by unresolved legal issues.

Guide for use: Example:

The child is unable to be discharged to either parent's care as custody issues related to the parent's divorce are currently being addressed within the legal system. At time of discharge, the custody issues were not yet resolved.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Guardianship issues

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about guardianship issues that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by guardianship issues.

Guide for use: Example:

The Child protection services are involved and determined that it is not safe for the child to return to the parent's care. Discharge may be delayed while the department is seeking an appropriate, alternative carer, e.g. awaiting a foster care placement.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Patient related issues (medical)

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about the child's medical status that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes where rehabilitation end was delayed because the child's condition was medically unstable.

Guide for use:
Example:
The child becomes medically unstable just before discharge and remains in hospital for medical treatment e.g. the child contracts gastroenteritis and becomes unwell.
The child suddenly requires an intervention that needs to be completed prior to returning home e.g. the child develops headaches and requires a CT scan.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Psychosocial issues

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about psychosocial issues within the family that have caused a delay in the child's discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by psychosocial issues within the family.

Guide for use: Example:

The child is ready to be discharged but the family have not yet been able to attend sufficient education regarding nursing or therapy care, provided by the rehabilitation team.

The child is ready to be discharged but the family continues to negotiate time off with their workplaces to continue caring for their child who is as yet unable to attend school full time.

Leave blank if you indicated that there was no delay in discharge

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Awaiting community support funding

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about community support funding issues that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by community support funding issues.

Guide for use: Example:

The child is ready to be discharged but the family are awaiting approval of a package through NDIS (National Disability Insurance Scheme) or funding support through NIIS (National Injury Insurance Scheme), to allow for community based services, equipment or modifications to be provided.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Awaiting community support availability

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about community support availability issues that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by community support availability.

Guide for use: Example:

The child is ready to be discharged but local community services are unable to commence intervention due to capacity or staffing issues.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Equipment issues

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about equipment issues that have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by equipment issues.

Guide for use: Example:

Specialist equipment required for discharge is not available at time of discharge e.g. wheelchair not available at the time of discharge.

If you would like to provide additional information please use the ‘General comments’ section.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Awaiting housing

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about lack of housing availability which may have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes where rehabilitation end was delayed because the child and family did not have housing available.

Guide for use: Example:

The family is on the waiting list for social housing (incorporating public housing, community housing and affordable housing) as provided by the state and territory governments.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Awaiting accessible housing

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about lack of accessible housing availability which may have caused a delay in discharge.

Justification: This item enables identification of the rehabilitation episodes where rehabilitation end was delayed because the child did not have accessible housing available.

Guide for use: Accessible housing refers to dwellings which have been constructed or modified (e.g. through renovation or home modification) to meet the needs of people with specific access requirements to enable independent and safe living.

Example:
Houses without steps or with ramps, which comply with Australian Standards and wheelchair accessible housing.

If the child and family are waiting for appropriately accessible housing to become available record ‘yes’.

Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Other

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about delays in discharge not elsewhere identified in the dataset.

Justification: This item enables identification of the rehabilitation episodes where rehabilitation end was delayed for reasons not elsewhere classified in the dataset.

Guide for use: Use this item for reasons which have caused a delay in discharge that are not elsewhere identified in the dataset.
Please carefully consider the use of this item, as 'other' contributes to non-specific data.
If you find a trend in your patient group that is not covered by the data options please contact AROC.

Example:
If a child's discharge is delayed while awaiting carer availability and funding e.g. ventilator training, choose 'Other', and then comment in the General comments field.

Codeset values:

1	Yes
2	No

Mode of episode end - Inpatient

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition:

This item records data about where the child went to at the end of their inpatient rehabilitation episode. There are two broad categories reflecting where the child can go:

1. Back to the community.
2. Remain in the hospital system.

Justification:

This data item defines how the child ended their rehabilitation journey. Different exit points are indicative of a child's progress in rehabilitation.

Guide for use:

The child can be discharged to the community, either directly to their final destination and what will be their home from now on, or to an interim destination. If the child is discharged to their final destination, provide final destination details under data item, “final destination.” If the child is discharged to "an interim destination", provide details of interim destination under data item, “interim destination” and then if known, details of their final destination under data item, “final destination.”

The other major option is that the child is discharged back to a hospital setting.

Please carefully consider the use of the code 9, “Other” as this contributes to non specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Discharged to final accommodation
2	Discharged to interim accommodation
3	Death
4	Discharged/transferred to another hospital - same state (AU) / DHB (NZ)
5	Discharged/transferred to another hospital - different state (AU) / DHB (NZ)
6	Discharged to another ward under the care of another specialty within the same hospital
8	Care type change to maintenance after rehab goals finished
9	Other

Mode of episode end - Ambulatory

Pathway: **Inpatient** ☐ **Ambulatory** ☑

Definition: This item records data about where the child went to at the end of their ambulatory rehabilitation episode.

Justification: This data item defines how the child ended their rehabilitation journey. Different exit points are indicative of a child's progress in rehabilitation.

Guide for use: The child can be discharged to the community, either directly to their final destination and what will be their home from now on, or to an interim destination. If the child is discharged to their final destination, provide final destination details under data item, “final destination.” If the child is discharged to "an interim destination", provide details of interim destination under data item, “interim destination” and then if known, details of their final destination under data item, “final destination.”
Please carefully consider the use of the code 9, “Other” as this contributes to non specific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Discharged to final accommodation
2	Discharged to interim accommodation
3	Death
9	Other

Discharged to ambulatory rehabilitation care

Pathway: **Inpatient** ☑ **Ambulatory** ☐

Definition: This item collects information about episodes which have a planned discharge to continuation of rehabilitation in an ambulatory setting e.g. day rehabilitation.

Justification: This item is collected to identify the rehabilitation episodes where the intended plan was continuation of rehabilitation in an ambulatory setting.

Guide for use: If the rehabilitation team has planned and referred the child for a continuation of rehabilitation for the same impairment in an ambulatory setting e.g. day rehabilitation, record 'yes'.

Codeset values:

1	Yes
2	No

Interim accommodation support at episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

This and the next item collect the type of accommodation support a child is going to receive post discharge from rehabilitation. An interim destination may be defined as accommodation that is only intended to be temporary, which the rehabilitation team considers as a 'middle step' to a final destination.

Justification:

This data item allows the facility to capture the fact the child is unable to be discharged to what is intended to be their final destination immediately after rehabilitation. Feedback from AROC members indicates that this scenario is quite common and may indicate complexity of the child's discharge, or the lack of equipment and/or services available to the child.

Guide for use:

Interim accommodation support acknowledges that the child has not been able to return to their planned final accommodation immediately post discharge, and that even though their rehabilitation is deemed complete, they still have one more step to complete before reaching their final destination.

Example:
Jessie was discharged to her local country hospital (as a maintenance patient, interim accommodation) whilst awaiting a foster carer to be identified.

Alex was discharged to his grandmother's home (interim accommodation) whilst awaiting completion of home modifications to his family home (final accommodation).

Only complete if recorded "discharged to interim destination" at mode of episode end. If final destination is known, complete data item "final destination" as well. Interim destination is about intentions, not time frames.

Note:
Only use 'in home support provided by family' to indicate family support over and above normal family support for a child of that age.

For Ronald McDonald Houses choose 'Other', and then comment in the General comments field.

Codeset values:

1	No post accommodation support
2	Institutional setting
3	In home support provided by family
4	In home support provided by external agency
5	Alternative placement
6	Hospital
8	Other

Final accommodation support at episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition:

Final accommodation support may be defined as the accommodation support that a child is discharged to that is the most appropriate long term accommodation support for the child.

Justification:

Type of accommodation before, during and after rehabilitation treatment is collected to reflect and compare where the child has come from (what was their usual accommodation) and where they are going to (what will become their usual accommodation). Comparison of accommodation pre and post rehabilitation is an indicator of rehabilitation outcome.

Guide for use:

Only complete if recorded “discharged to final destination” or “discharged to interim destination” at mode of episode end.

Note:
For ‘group home’ choose ‘institutional setting’.

Only use ‘in home support provided by family’ to indicate family support over and above normal family support for a child of that age.

For ‘foster care’ and ‘out of home care’ choose ‘alternative placement’.

Codeset values:

1	No post accommodation support
2	Institutional setting
3	In home support provided by family
4	In home support provided by external agency
5	Alternative placement
8	Other

Community support at episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: This item identifies whether community support will be received by the child and family/carer at episode end. This includes both paid and/or unpaid community support(s).

Justification: The type of community support(s) required by the child and family/carer before and after rehabilitation can be compared as an indicator of the child's rehabilitation outcomes and any change in the child's functional independence.

Guide for use: Record 1, 'Yes' if the child and family/carer will receive community support at episode end and 2, 'No' if the child and family/carer will not receive community support. If 'Yes', complete the next question regarding the type of community support that will be received.

Codeset values:

1	Yes
2	No

Type of community support at episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: The level of community support that the child and family/carer will receive at the end of the current inpatient or ambulatory admission. This includes both paid and/or unpaid community supports received.

Justification: The type of community support before and after rehabilitation are collected to reflect and compare what level of support the child required in their usual accommodation and what additional support may be required after discharge from rehabilitation.

Guide for use: Record the type(s) of community support to be received by the child and family/carer at episode end.

Therapy support for individuals: e.g. the child will receive ongoing speech and language services to help address a developmental delay in communication skills.

Early childhood intervention: e.g. the child will be under the care of an early intervention team based approach to help address global delays in development. This implies more than one discipline supporting the child and is often seen in preschool age children.

Specialist behavioural/mental health services: e.g. the child will be receiving specialist mental health services such as (Child and Youth Mental Health) or a behavioural psychologist to support the child's functioning e.g. anxiety or behavioural concerns.

Counselling (individual/family/group): e.g. the child and/or the family will be receiving family therapy or counselling e.g. in relation to a divorce.

Case management and coordination: e.g. the child will receive a compensation payout and the family will employ a case manager to help source and coordinate services.

Respite: the child will receive respite services either in their own home or through a different accommodation venue e.g. the child will stay with a different family one weekend/month.

Other Community support: If you record 'Yes' please comment regarding the type of community support received in the General comments field.

Data Items:

Therapy support for individuals

Early childhood intervention

Specialist behaviour/mental health services

Counselling (individual/family/group)

Case management and co-ordination

Respite

Other community support

Codeset values:

1	Yes
2	No

School/day care support at episode end

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Any support which will be provided to the child in the educational setting after this rehabilitation episode. This support is in addition to that offered in a typical classroom situation e.g. a child who receives additional support with reading from the teacher's aide as part of a small group, should not be included. However, a child who requires a full time teacher's aides to manage their behaviour within the typical classroom should be recorded as "yes".

Justification: The support required by a child to attend school/day care before and after rehabilitation can be compared as an indicator of any change in the child's functional independence after rehabilitation.

Guide for use: Record whether the child will receive school/day care support.

Codeset values:

1	Yes
2	No
3	Child does not attend school/day care

General comments

Pathway: **Inpatient** ☑ **Ambulatory** ☑

Definition: Comments relevant to this episode of care.

Justification: N/A

Guide for use: N/A