# AROC Paediatric Data Dictionary for Clinicians

## Path

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

**Definition:**

Inpatient direct rehabilitation 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 'sharecare' model.

Ambulatory direct care rehabilitation:
- 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, eg Botulinum Toxin Clinics.

**Justification:**

**Guide for use:**

**Codeset values:**

**03** Inpatient Direct Care

**04** Ambulatory Direct Care

## Establishment ID

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

**Definition:** A code which represents the facility.

**Justification:**

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

## Establishment Name

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

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

**Justification:**

**Guide for use:**

## 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 manadatory to collect this data item if the facility has only one rehabilitation ward/team.

While Ward Code 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 Code 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 Code is at the facility's discretion. To try and reduce errors in data entry AROC suggest keeping the Ward Code 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 manadatory 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 kept consistent with every episode that is treated on that ward.

## Unique Record Number

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

**Definition:** Unique record number assigned by the facility to a patient.

**Justification:**

**Guide for use:** This is the unique record number assigned to the patient, by a facility.

## Letters of Name

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

| | |
|---|---|
| **Definition:** | Letters of name is a 5 letter word made up of the 2nd, 3rd and 5th letters of the patient's surname, followed by the 2nd and 3rd letters of the patient's first name. |
| **Justification:** | This information forms part of the statistical key (SLK) used by AROC to link patient's episodes through their rehabilitation journey. |
| **Guide for use:** | In the first three spaces record the 2nd, 3rd and 5th letters of the patient's surname. In the following two spaces, record the 2nd and 3rd letters of the patient'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 person 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 patient's episodes through their rehabilitation journey. |
| **Guide for use:** | Enter in format DD/MM/YYYY.<br>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:**

**Codeset values:**

**01** Male

**02** Female

**03** Indeterminate

**09** Not stated/inadequately defined

## Indigenous Status (AU)

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

**Definition:** Indigenous status is a measure of whether a patient 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:**

**Codeset values:**

**01** Aboriginal but not Torres Strait Islander origin

**02** Torres Strait Islander but not Aboriginal origin

**03** Both Aboriginal and Torres Strait Islander origin

**04** Neither Aboriginal nor Torres Strait Islander origin

**09** 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:**

**01** NSW
**02** VIC
**03** QLD
**04** SA
**05** WA
**06** TAS
**07** NT
**08** ACT
**09** 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. Record the postcode of the child's usual place of residence. |
| **Justification:** | This information may be used for identification of referral patterns and for analysis of outcomes by 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:**

Record the date that 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 dependant 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 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' e.g. Rehabilitation for a child with ABI under the care of the acute neurosurgical team, is the date the rehabilitation team starts working with the patient, regardless of the bed card classification.

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 through the rehabilitation episode.

**Guide for use:**

Record the date that the child commenced rehabilitation care.

## Episode end date

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

| | |
|---|---|
| **Definition:** | Record the date that the child completes their rehabilitation episode. This date defines the end of the rehabilitation episode and is the date at which the length of stay (LOS) concludes.<br>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).<br>Ambulatory rehabilitation 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. maintenance, either inpatient or ambulatory. |
| **Justification:** | This item is required to establish time periods between critical points through the rehabilitation episode. |
| **Guide for use:** | Record the date that the child completes their rehabilitation episode or when the child does not come back for treatment (ambulatory), or when the child is discharged by the family at their own risk. |

## Funding Source (AU)

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

**Definition:** The principal source of funding for the child in rehabilitation.

**Justification:** Collection of this data item enables AROC to distinguish rehabilitation episodes of care based on the funding source (a 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:**

**01** Australian Health Care Agreement (public patient)
**02** Private Health Insurance
**03** Self-funded
**04** Workers compensation
**05** Motor vehicle third party personal claim
**06** Other compensation (e.g. public liability, common law, medical negligence)
**07** Department of Veterans' Affairs
**08** Department of Defence
**09** 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:** The principal source of funding for the child in rehabilitation.

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

**Guide for use:** Code corresponding to the person'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:**

**01** ACA Health Benefits Fund
**02** 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
**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

## National Disability Insurance Scheme (NDIS)

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

**Definition:** Record the eligibility status of the child within the The National Disability Insurance Scheme (NDIS). 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.

**Justification:** The involvement of the child and family in the NDIS before and after rehabilitation can be compared as an indicator of the child's rehabilitation outcomes and identify service provider groups following a rehabilitation episode of care.

**Guide for use:**

**Codeset values:**

**01** Eligible - on a plan

**02** Eligible - waiting

**03** Awaiting eligibility determination

**04** Eligible - hasn't applied

**05** 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 impairments 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:** Refer to the AROC Impairment Codes Coding Guidelines attached, which were developed to assist 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.

Some examples:
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:** Record 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/event and admission to rehabilitation, and analyse this against outcomes achieved.

**Guide for use:** This data element is one of a data pair. It 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/event and admission to rehabilitation, and analyse this 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 neurological disease with an insidious onset, and 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 1 month".

**Codeset values:**

**01** Less than one month ago
**02** 1 month to less than 3 months
**03** 3 months to less than 6 months
**04** 6 months to less than a year
**05** 1 year to less than 2 years
**06** 2 years to less than 5 years
**07** 5 or more years
**09** Unknown

## Referral Date

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

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

**Justification:** This item is being collected to measure the impact of delay between date referral RECEIVED and date rehabilitation started. Please note: Date referral RECEIVED is being collected and not date the referral was made, because at times these dates may differ and it was deemed unfair 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.
Referrals can be made by phone, fax or face to face across all settings.
Examples include:
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” 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. Record the date the child is ready for rehabilitation and not the date rehabilitation actually started. |
| **Justification:** | This item is being 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 clinically ready for rehabilitation and not the date rehabilitation actually started. |

## 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 appropriate for rehabilitation and the rehabilitation program starting.

**Justification:** This item is being 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:**

**01** Yes

**02** 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 appropriate for rehabilitation and the rehabilitation program starting.

**Justification:** This item is required to be able to identify the rehabilitation episodes whose rehabilitation start was delayed by patient related medical issues.

**Guide for use:** Examples include:
The child is not medically stable; he was assessed as appropriate for rehabilitation, but has developed fevers and can only be admitted once he has been 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:**

**01** Yes

**02** No

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

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

**Definition:**

This item collects information about service issues that have caused a delay between the child being assessed as appropriate for rehabilitation and the rehabilitation program starting.

**Justification:**

This item is required to be able to identify the rehabilitation episodes whose rehabilitation start was delayed by service issues.

**Guide for use:**

Examples include:
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:**

**01** Yes

**02** 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 appropriate for rehabilitation and the rehabilitation program starting.

**Justification:**
This item is required to be able to identify the rehabilitation episodes whose rehabilitation start was delayed by service issues.

**Guide for use:**
Examples include:
No available beds in the paediatric rehabilitation ward or unit, so the child is unable to be transferred from a different facility until a bed in the rehabilitation ward or unit becomes available.
No rehabilitation beds are available; 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:**

**01** Yes

**02** 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 appropriate for rehabilitation and the rehabilitation program starting.

**Justification:**
This item is required to be able to identify the rehabilitation episodes whose rehabilitation start was delayed by external support issues.

**Guide for use:**
Examples include:
Education about clinical needs of the child need to be completed prior to transfer to rehabilitation i.e: 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 from acute service to rehabilitation service or alternate accommodation in the community.
Lack of availability of family/friend support. For example, 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:**

**01** Yes
**02** 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 appropriate for rehabilitation and the rehabilitation program starting.

**Justification:** This item is required to be able to identify the rehabilitation episodes whose rehabilitation start was delayed by equipment issues.

**Guide for use:** Examples include:
The child requires specialist adult-sized equipment, which the ward does not have available and needs 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:**

**01** Yes

**02** 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 appropriate for rehabilitation and the rehabilitation program starting.

**Justification:** This item is required to be able to identify the rehabilitation episodes whose rehabilitation start was delayed by patient behavioural issues.

**Guide for use:** Examples include:
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:**

**01** Yes

**02** No

# Mode of Episode Start - Inpatient

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

**Definition:** This item records data about where the child came from when the inpatient rehabilitation episode started.

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

**Guide for use:** 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" may be defined as the child's regular fixed abode e.g. their own home/foster care setting.
"Other than usual accommodation" may be defined as temporary accommodation e.g. the child and family were away on holiday or business or visiting family and friends when he was injured and was admitted to hospital.

**Codeset values:**

**01** Admitted from usual accommodation

**02** Admitted from other than usual accommodation

**03** Transferred from another hospital – same state (AU) / DHB (NZ)

**04** Transferred from another hospital – different state (AU) / DHB (NZ)

**05** Transferred from under the care of a different speciality within the same hospital

**06** Other

## Mode of Episode Start - Ambulatory

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

**Definition:** This item records data about where the referral source for the ambulatory rehabilitation episode started.

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

**Guide for use:** Record the referral source for the rehabilitation episode.
For example: a child may be referred from the acute setting in the same hospital directly into an ambulatory rehabilitation program of care. Others 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:**

**01** Referred by General Practitioner
**02** Referred by community based therapist
**03** Referred by same hospital
**04** Referred from another hospital – same state (AU) / DHB (NZ)
**05** Referred from another hospital – different state state (AU) / DHB (NZ)
**06** 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 (ie within one week) inpatient rehabilitation care.

**Justification:** This item is collected to identify rehabilitation episodes which are a continuation of inpatient rehabilitation care.

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

**Codeset values:**

**01** Yes

**01** No

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

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

**Definition:**

"Direct care" is when the child is directly under the care of the rehabilitation physician or team, that is, the rehabilitation physician or team hold the "bed card"/medical governance for the child. An episode of direct care can be provided in the inpatient setting, day rehab, outpatient and/ or community setting.

For example, 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.

If a child who has had a TBI, was admitted for inpatient rehabilitation, and subsequently undertakes an ambulatory rehabilitation episode, the inpatient rehabilitation episode is classified as the first direct episode of rehabiltation care.

If a child is admitted directly to an ambulatory rehabilitation program after having a TBI, then this is classified as their first direct episode of rehabilitation care for their TBI.

**Justification:**

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

**Guide for use:**

The item relates to the child's impairment NOT the particular hospital. For example, if a previous episode of direct rehabilitation care for the current impairment has taken place in a different hospital, enter 2 , "No" as this admission will not be the first episode of direct rehabilitation care for this impairment. Subsequent direct rehabilitation episodes of care are more common in certain impairments such as brain injury or spinal cord injury, where the child often has multiple rehabilitation episodes across a variety of settings e.g. 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. This would be coded as 2, "No".

**Codeset values:**

**01** Yes

**02** No

## Need for interpreter service?

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

**Definition:** Record whether an interpreter service (paid or unpaid e.g. family member) is required for 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:**

**Codeset values:**

**01** Interpreter needed and used

**02** Interpreter needed and not used

**03** Interpreter not needed

## Accommodation Support Prior

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

**Definition:** The type of support the child 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 carers 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 been receiving any additional accommodation support prior to the admission but will be discharged to an alternative placement such as a foster home.

**Codeset values:**

**01** No prior accommodation support

**02** Institutional setting

**03** In home suppport

**04** Alternative placement (including foster home)

**05** Other

## Community Support prior to admission

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

**Definition:** Record the level of community support that the child and family/carers received prior to the current inpatient or ambulatory admission. This includes both paid and/or unpaid community supports received.

**Justification:** The type of community supports required by the child and family/carers before and after rehabilitation can be compared as an indicator of the child's rehabilitation outcomes.

**Guide for use:**
No prior community support: the child and family have not been accessing any additional community supports e.g. such as therapy.
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 co-ordination: 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.

**Codeset values:**

**01** No prior community support
**02** Therapy suppoprt for individuals
**03** Early childhood intervention
**04** Specialist behaviour/mental health services
**05** Counselling (individual/ family/ group)
**06** Regional resource and support teams
**07** Case management and co-ordination
**08** Respite
**09** Other community support

## 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:**

**Codeset values:**

**01** Yes

**02** No

**03** Child does not attend school/day care

## Type of accommodation during day program

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

**Definition:**
Record 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 during this ambulatory episode of care, only answer 6, “not in interim accommodation”, if the addresses before and during the rehabilitation episode are the same. e.g. Charlie lived at 13 Mornington Cresent before and during this ambulatory episode of care.
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 ie: 1, "interim accommodation due to geographical (access) issues", 2, "Interim accommodation due to increased support needs" and so forth.
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 can not yet manage.

**Codeset values:**

**01** Interim accommodation due to geographical needs
**02** Interim accommodation due to increased support needs
**03** Interim accommodation due to change in pre-rehabilitation living arrangements required
**04** Interim accommodation due to awaiting guardianship
**05** Interim accommodation for other reason
**06** Not in interim accommodation

## Is there an existing comorbidity interfering with this episode

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

**Definition:**

This item identifies whether the child had any other significant existing illness/impairment, which were not part of the principal presenting condition, and which were observed to impact on the child's ability to participate in the rehabilitation program. For example, if the child has a cardiac condition, limitations on ability to participate may not be initially apparent.

**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. For example, the child required extensive medication management for diabetes and had variability in blood sugar levels during the admission that affected their ability to participate, the child required a longer length of stay to accommodate sever failure to thrive, or the 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:**

**01** Yes

**02** No

# Comorbidities Interfering with Rehabiliation 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.

Examples:
If a child has ADHD and it is impacting their ability to participate in rehabilitation, code as 'behavioural'.
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:**

**01** Cardiac conditions
**02** Respiratory Conditions
**03** Amputation
**04** Congenital condition with intellectual impairment
**05** Congenital condition with physical impairment
**06** Acquired intellectual impairment
**07** Acquired physical Impairment
**08** Skin conditions
**09** 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. For example, a child with a spinal cord injury on bed rest developed a pressure injury which prevented him from engaging at the anticipated intensity in his planned rehabilitation program OR a child developed a UTI, became unwell and was unable to engage at the anticipated intensity in his 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:**

**01** Yes

**02** No

## Complications interfering with this episode

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** This item identifies which complication(s) prevented the child from engaging at the anticipated intensity in their planned rehabilitation program.

**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, choose 'Other', and then record a specific comment in the 'General Comments' field.

**Data Items:**

**Complication interfering with this episode 1**
**Complication interfering with this episode 2**
**Complication interfering with this episode 3**
**Complication interfering with this episode 4**

**Codeset values:**

**01** UTI
**02** Pressure injury
**03** Wound infection
**04** Infection other than wound/UTI (Including gastroenteritis, respiratory, otitis media, chicken pox)
**05** Neurosurgical complications
**06** Neurological complications
**07** Orthopaedic complications (Including fracture, HO, osteomyelitis)
**08** DVT
**09** Other

## Date multi-disciplinary 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. Record the date the multidisciplinary team rehabilitation plan was first recorded. |
| **Justification:** | The establishment of a multidisciplinary team rehabilitation plan with regular review is necessary for effective patient 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. |

## Date episode start WeeFIM assessed

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

| | |
|---|---|
| **Definition:** | Record the date that the child's admission WeeFIM was completed. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection. |
| **Justification:** | This item reflects timely assessment of function on admission. |
| **Guide for use:** | Admission WeeFIM scoring needs to be completed within 72 hours of patient admission. Assessment is complete when the last item of the WeeFIM assessment is completed and the time stamp should be the date on which this occurs. Even if the recording of this date happens on a day subsequent to the day the last item of the WeeFIM assessment was completed, the date recorded must be the date the last item of the WeeFIM assessment was scored. |

## Admission WeeFIM scores

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** Record the child's WeeFIM score for each of the 18 WeeFIM items, assessed at the time of admission. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.

**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.

**Guide for use:** Admission WeeFIM scoring needs to be completed within 72 hours of patient admission.

**Data Items:**

**Admission WeeFIM score for eating**
**Admission WeeFIM score for grooming**
**Admission WeeFIM score for bathing**
**Admission WeeFIM score for dressing upper body**
**Admission WeeFIM score for dressing lower body**
**Admission WeeFIM score for toileting**
**Admission WeeFIM score for bladder management**
**Admission WeeFIM score for bowel management**
**Admission WeeFIM score for transfer to bed/chair/wheelchair**
**Admission WeeFIM score for transfer to toilet**
**Admission WeeFIM score for transfer to shower/tub**
**Admission WeeFIM score for locomotion**
**Admission WeeFIM score for stairs**
**Admission WeeFIM score for comprehension**
**Admission WeeFIM score for expression**
**Admission WeeFIM score for social interaction**
**Admission WeeFIM score for problem solving**
**Admission WeeFIM score for memory**

**Codeset values:**

| | |
|---|---|
| **01** | Total contact assistance |
| **02** | Maximal contact assistance |
| **03** | Moderate contact assistance |
| **04** | Minimal contact assistance |
| **05** | Supervision or setup |
| **06** | Modified independence |
| **07** | Complete independence |

## Date episode end WeeFIM assessed

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

**Definition:** Record the date that the child's discharge WeeFIM scores were scored. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.

**Justification:** This item reflects timely assessment of function on discharge.

**Guide for use:** Discharge WeeFIM scoring needs to be completed before the child is discharged from the rehabilitation program, but ideally no more than 72 hours BEFORE the episode ends. Assessment is complete when the last item of the WeeFIM assessment is completed and the time stamp should be the date on which this occurs. Even if the recording of this date happens on a day subsequent to the day the last item of the WeeFIM assessment was completed, the date recorded must be the date the last item of the WeeFIM assessment was scored.

## Discharge WeeFIM scores

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** Record the child's WeeFIM score for each of the 18 WeeFIM items, assessed at the time of discharge. This item is mandatory for the inpatient data collection. It is optional for the ambulatory data collection.

**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.

**Guide for use:** Discharge WeeFIM scoring needs to be completed within 72 hours BEFORE patient discharge.

### Data Items:

**Discharge WeeFIM score for eating**
**Discharge WeeFIM score for grooming**
**Discharge WeeFIM score for bathing**
**Discharge WeeFIM score for dressing upper body**
**Discharge WeeFIM score for dressing lower body**
**Discharge WeeFIM score for toileting**
**Discharge WeeFIM score for bladder management**
**Discharge WeeFIM score for bowel management**
**Discharge WeeFIM score for transfer to bed/chair/wheelchair**
**Discharge WeeFIM score for transfer to toilet**
**Discharge WeeFIM score for transfer to shower/tub**
**Discharge WeeFIM score for locomotion**
**Discharge WeeFIM score for stairs**
**Discharge WeeFIM score for comprehension**
**Discharge WeeFIM score for expression**
**Discharge WeeFIM score for social interaction**
**Discharge WeeFIM score for problem solving**
**Discharge WeeFIM score for memory**

### Codeset values:

**01** Total contact assistance
**02** Maximal contact assistance
**03** Moderate contact assistance
**04** Minimal contact assistance
**05** Supervision or setup
**06** Modified independence
**07** Complete independence

## COPM Start Date

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

| | |
|---|---|
| **Definition:** | The date the Canadian Occupational Performance Measure (COPM) was administered at episode start. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection. |
| **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. |
| **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. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection.

**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.

**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.

**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:**

| | |
|---|---|
| **01** | 1 |
| **02** | 2 |
| **03** | 3 |
| **04** | 4 |
| **05** | 5 |
| **06** | 6 |
| **07** | 7 |
| **08** | 8 |
| **09** | 9 |
| **10** | 10 |

## COPM End Date

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

| | |
|---|---|
| **Definition:** | The date the Canadian Occupational Performance Measure (COPM) was administered at episode end. This item is mandatory for the ambulatory data collection. It is optional for the inpatient data collection. |
| **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. |
| **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.

**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:**

| | |
|---|---|
| **01** | 1 |
| **02** | 2 |
| **03** | 3 |
| **04** | 4 |
| **05** | 5 |
| **06** | 6 |
| **07** | 7 |
| **08** | 8 |
| **09** | 9 |
| **10** | 10 |

## Functional Mobility Scale (FMS) start date

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

| | |
|---|---|
| **Definition:** | Record the date on which the FMS assessment was scored at episode start (admission). |
| **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. |

## Score episode start for FMS - distance 5 metres

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

**Definition:** Record the FMS score for walking distance - 5 metres on admission of the episode 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:**

**01** 1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.

**02** 2 - Uses a walker or frame, without help from another person.

**03** 3 - Uses crutches, without help from another person.

**04** 4 - Uses sticks (one or two), without help from another person.

**05** 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.

**06** 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.

**07** Crawling - Child crawls for mobility at home

**08** None - Does not apply, for example the child does not complete the distance

## Score episode start for FMS - walking distance 50 metres

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

**Definition:** Record the FMS score for walking distance - 50 metres on admission of the episode 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:**

**01** 1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.

**02** 2 - Uses a walker or frame, without help from another person.

**03** 3 - Uses crutches, without help from another person.

**04** 4 - Uses sticks (one or two), without help from another person.

**05** 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.

**06** 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.

**08** None - Does not apply, for example the child does not complete the distance.

## Score episode start for FMS - walking distance 500 metres

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

**Definition:** Record the FMS score for walking distance - 500 metres on admission of the episode 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:**

**01** 1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.

**02** 2 - Uses a walker or frame, without help from another person.

**03** 3 - Uses crutches, without help from another person.

**04** 4 - Uses sticks (one or two), without help from another person.

**05** 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.

**06** 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.

**08** None - Does not apply, for example the child does not complete the distance.

## Functional Mobility Scale (FMS) end date

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

| | |
|---|---|
| **Definition:** | Record the date on which the FMS assessment was scored at episode end (discharge) |
| **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. |

## Score episode end for FMS - walking distance 5 metres

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

**Definition:** Record the FMS score for walking distance - 5 metres on discharge of the episode 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.

**Codeset values:**

**01** 1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.

**02** 2 - Uses a walker or frame, without help from another person.

**03** 3 - Uses crutches, without help from another person.

**04** 4 - Uses sticks (one or two), without help from another person.

**05** 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.

**06** 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.

**07** Crawling - Child crawls for mobility at home

**08** None - Does not apply, for example the child does not complete the distance

## Score episode end for FMS - walking distance 50 metres

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

**Definition:** Record the FMS score for walking distance - 50 metres on discharge of the episode 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.

**Codeset values:**

**01** 1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.

**02** 2 - Uses a walker or frame, without help from another person.

**03** 3 - Uses crutches, without help from another person.

**04** 4 - Uses sticks (one or two), without help from another person.

**05** 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.

**06** 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.

**08** None - Does not apply, for example the child does not complete the distance.

## Score episode end for FMS - walking distance 500 metres

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

**Definition:** Record the FMS score for walking distance - 500 metres on discharge of the episode 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.

**Codeset values:**

**01** 1 - Uses wheelchair, may stand for transfers, may do some stepping supported by another person or using a walker/frame.

**02** 2 - Uses a walker or frame, without help from another person.

**03** 3 - Uses crutches, without help from another person.

**04** 4 - Uses sticks (one or two), without help from another person.

**05** 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.

**06** 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.

**08** None - Does not apply, for example the child does not complete the distance.

## PEDI Start Date

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

**Definition:** The date the initial PEDI was administered. This is an OPTIONAL item.

**Justification:** The Paediatric Evaluation of Disability Inventory (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

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

## PEDI Start Self Care Total

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

| | |
|---|---|
| **Definition:** | The 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 socre. 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 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 socre. 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 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 socre. 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:** PEDI caregiver assistance for self care activities at episode start.

**Justification:**

**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:**

| | |
|---|---|
| **00** | 0 - Total assistance |
| **01** | 1 - Maximal |
| **02** | 2 - Moderate |
| **03** | 3 - Minimal |
| **04** | 4 - Supervision |
| **05** | 5 - Independent |

## PEDI Start Self Care: Modification

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI modification to self care activities at episode start.

**Justification:**

**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:**

**01** None
**02** Child
**03** Rehab
**04** Extensive

## PEDI Start Mobility: Caregiver Assessment

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI caregiver assistance for mobility activities at episode start.

**Justification:**

**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:**

**00** 0 - Total assistance
**01** 1 - Maximal
**02** 2 - Moderate
**03** 3 - Minimal
**04** 4 - Supervision
**05** 5 - Independent

# PEDI Start Mobility: Modification

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI modification to mobility activities at episode start.

**Justification:**

**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:**

**01** None
**02** Child
**03** Rehab
**04** Extensive

## PEDI Start Social Function: Caregiver Assistance

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI caregiver assistance for social function activities at episode start.

**Justification:**

**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:**

**00** 0 - Total assistance
**01** 1 - Maximal
**02** 2 - Moderate
**03** 3 - Minimal
**04** 4 - Supervision
**05** 5 - Independent

# PEDI Start Social Function: Modification

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

**Definition:** PEDI modification to social function activities at episode start.

**Justification:**

**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:**

**01** None

**02** Child

**03** Rehab

**04** Extensive

## PEDI End Date

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

**Definition:** The date the PEDI was administered at episode end. This is an OPTIONAL item.

**Justification:** The Paediatric Evaluation of Disability Inventory (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

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

## PEDI End Self Care Total

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

| | |
|---|---|
| **Definition:** | The 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 socre. 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 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 socre. 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 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 socre. 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:** PEDI caregiver assistance for self care activities at episode end.

**Justification:**

**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:**

| | |
|---|---|
| **00** | 0 - Total assistance |
| **01** | 1 - Maximal |
| **02** | 2 - Moderate |
| **03** | 3 - Minimal |
| **04** | 4 - Supervision |
| **05** | 5 - Independent |

# PEDI End Self Care: Modification

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI modification to self care activities at episode end.

**Justification:**

**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:**

**01** None
**02** Child
**03** Rehab
**04** Extensive

## PEDI End Mobility: Caregiver Assistance

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

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

**Justification:**

**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:**

| | |
|---|---|
| **00** | 0 - Total assistance |
| **01** | 1 - Maximal |
| **02** | 2 - Moderate |
| **03** | 3 - Minimal |
| **04** | 4 - Supervision |
| **05** | 5 - Independent |

# PEDI End Mobility: Modification

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI modification to mobility activities at episode end.

**Justification:**

**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:**

**01** None

**02** Child

**03** Rehab

**04** Extensive

## PEDI End Social Function: Caregiver Assistance

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI caregiver assistance for social function activities at episode end.

**Justification:**

**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:**

**00** 0 - Total assistance
**01** 1 - Maximal
**02** 2 - Moderate
**03** 3 - Minimal
**04** 4 - Supervision
**05** 5 - Independent

# PEDI End Social Function: Modification

**Pathway:** **Inpatient** ✓ **Ambulatory** ✓

**Definition:** PEDI modification to social function activities at episode end.

**Justification:**

**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:**

**01** None

**02** Child

**03** Rehab

**04** 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:**

**01** Yes

**02** No

**09** Unknown

## Home visit date

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

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

**Justification:**

**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 visit may be defined as a therapy/nursing visit to the child's school or daycare visit 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 school visit to the child's school or daycare was completed.

**Codeset values:**

**01** Yes

**02** No

**09** Unknown

## School visit date

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

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

**Justification:**

**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, ie ‘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 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 childs rehabilitation.
Example: a month before discharge, Ebony trialled an overnight stay at her own home. It was successful, so the family spent 2 days over each weekend 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:**

It is recognised that there may be a number of reasons for the suspension of a rehabilitation program:
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'.

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.

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).

For 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. Next 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.

## Total number of suspension occurrences

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

**Definition:** Record the total number of rehabilitation treatment suspension occurances 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 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 developes gastroenteritis and he is unable to undertake his rehab program on Thursday and Friday. He starts again on Monday. Next 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:** | Record the total number of days that service(s) were 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 services were provided to the child. |
| **Guide for use:** | In the ambulatory setting, this should total all days that service(s) were 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. |

## Total number of occasions of service

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

**Definition:** Record the total number of occasions of service to the child. 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:** In the ambulatory setting, this should be the total of all occasions of service(s) that were provided to the child. 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:** Record the type(s) of health professional or other care provider who provided treatment to the child during their rehabilitation episode of care.

**Justification:** This item is required to enable analysis of 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, eg '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:**

| | |
|---|---|
| **01** | Care coordinator |
| **02** | Occupational therapist |
| **03** | Physiotherapist |
| **04** | Rehabilitation therapist |
| **05** | Paediatrician |
| **06** | Neuropsychologist |
| **07** | Social worker |
| **08** | Speech pathologist/therapist |
| **09** | 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:** Record whether any other teams provided input into management for the child and family during their ambulatory rehabilitation episode.

**Justification:**

**Guide for use:**

**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:**

**01** Yes

**02** No

## Date clinically ready for discharge

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

| | |
|---|---|
| **Definition:** | A child is clinically ready for discharge when the treating multidisciplinary team determines that there are no further rehabilitation goals that require ongoing inpatient rehabilitation and any ongoing rehabilitation needs can be adequately met by services available outside the inpatient setting.<br><br>A child in an ambulatory program is clinically ready for discharge when the treating multidisciplinary team determines that there are no further rehabilitation goals that require ongoing treatment or that any further goals will be addressed by another provider. |
| **Justification:** | Anecdotedly the date a child is clinically ready for discharge is not always the same as the actual discharge date. At times, there are delays. This item is collected to enable 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 clinically ready for discharge 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.

**Justification:** This item is being 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:**

**01** Yes

**02** 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 is required to be able to identify the rehabilitation episodes whose rehabilitation end was delayed due to waiting for home modifications.

**Guide for use:** Examples include:
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.

**Codeset values:**

**01** Yes

**02** No

## Reason for delay in discharge - Legal issues

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

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

**Justification:** This item is required to be able to identify the rehabilitation episodes whose rehabilitation discharge was delayed by unresolved legal issues.

**Guide for use:** 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.

**Codeset values:**

**01** Yes

**02** 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 is required to be able to identify the rehabilitation episodes whose discharge was delayed by guardianship issues.

**Guide for use:** The Department of Child Safety 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 carer placement.

**Codeset values:**

**01** Yes

**02** No

## Reason for delay in discharge - Medically unstable

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

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

**Justification:** This item is required to be able to identify the rehabilitation episodes where discharge was delayed because the child was medically unstable.

**Guide for use:** Examples Include:
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.

**Codeset values:**

**01** Yes
**02** No

## Reason for delay in discharge - Psychosocial issues

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

**Definition:** This item collects information about psychosocial issues in the family that have caused a delay in discharge.

**Justification:** This item is required to be able to identify the rehabilitation episodes whose discharge was delayed by psychosocial issues in the family

**Guide for use:** Examples include: 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.

**Codeset values:**

**01** Yes

**02** 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 is required to be able to identify the rehabilitation episodes whose discharge was delayed by community support funding issues.

**Guide for use:** 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.

**Codeset values:**

**01** Yes

**02** 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 is required to be able to identify the rehabilitation episodes whose rehabilitation discharge was delayed by community support availability.

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

**Codeset values:**

**01** Yes

**02** 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 is required to be able to identify the rehabilitation episodes whose discharge was delayed by equipment issues.

**Guide for use:** Examples include: 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:**

**01** Yes

**02** 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 is required to identify the rehabilitation episodes where discharge was delayed because the child did not have housing available.

**Guide for use:** If the child and family are waiting for housing to become available, e.g. 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 record ‘yes’.

**Codeset values:**

**01** Yes

**02** 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 is required to identify the rehabilitation episodes where discharge 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 higher level access requirements to enable independent and safe living. Examples include 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’.

**Codeset values:**

**01** Yes

**02** 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 is required to identify the rehabilitation episodes where discharge was delayed for reasons not elsewhere identified 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 eg ventilator training, choose 'Other', and then comment in the 'General Comments' field.

**Codeset values:**

**01** Yes
**02** 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 items 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. The other major option is that the child is discharged back to a hospital setting. 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:**

**01** Discharged to final accommodation
**02** Discharged to interim accommodation
**03** Death
**04** Discharged/transferred to another hospital - same state (AU) / DHB (NZ)
**05** Discharged/transferred to another hospital - different state (AU) / DHB (NZ)
**06** Discharged to another ward under the care og another specialty within the same hospital
**08** Care type change to maintenance after rehab goals finished
**09** 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 items 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:**

**01** Discharged to final accommodation

**02** Discharged to interim accommodation

**03** Death

**09** 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:**

**01** Yes

**02** 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 e.g. Jessie was discharged to her local country hospital (as a maintenance patient, interim accommodation) whilst awaiting a foster carer to be identified OR 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: for Ronald McDonald Houses choose ‘Other’, and then comment in the ‘General Comments’ field.

**Codeset values:**

**01** No post accommodation support
**02** Institutional setting
**03** In home support
**04** Alternative placement
**05** Hospital
**06** 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’
For ‘Foster care’ and ‘out of home care’ choose ‘alternative placement’

**Codeset values:**

**01** No post accommodation support
**02** Institutional setting
**03** In home support
**04** Alternative placement
**05** Other

## Community Support at episode end

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

**Definition:**
The type of community support the child was receiving with respect to his usual accommodation after the rehabilitation episode of care.

**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:**
No community support at episode end: the child and family will not be accessing any additional community supports e.g. therapy.
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 co-ordination: 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.

**Codeset values:**

**01** No community support at episode end
**02** Therapy support for individuals
**03** Early childhood intervention
**04** Specialist behaviour/mental health services
**05** Counselling (individual/ family/ group)
**06** Regional resource and support teams
**07** Case management and co-ordination
**08** Respite
**09** Other Community Support

## School/day care support at episode end

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

**Definition:** This item identifies whether any support will be provided to the child in the educational setting after this 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:**

**Codeset values:**

**01** Yes

**02** No

**03** Child does not attend school/day care

## General Comments

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

**Definition:** Comments relevant to this episode of care.

**Justification:**

**Guide for use:**