AUSTRALASIAN REHABILITATION OUTCOMES CENTRE

INPATIENT DATA DICTIONARY V4

FOR CLINICIANS - AUSTRALIAN VERSION

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

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Inpatient Data Dictionary for Clinicans

BACKGROUND

This data dictionary includes all of the data items that are in the AROC Inpatient V4 dataset. Each data item is listed, along with the definition, justification and guide for use. The language and information is aimed to assist clinically trained staff in using and understanding the AROC data. AROC recommends that this dictionary is used as a support document for staff members collecting data on our data collection forms. If you find that this dictionary does not adequately clarify your query of a data item, please contact aroc@uow.edu.au.

INPATIENT DATA DICTIONARY VERSION

Version	Date	Nature of change
4.01	June 2019	This is the first edition of the AROC Inpatient Data Dictionary. Converted from the AROC Data Dictionary to the AROC Inpatient Data Dictionary with formatting changes and the removal of Ambulatory data items and information from the Inpatient dictionary. Minor dataset changes to the following items: • *AROC Impairment Code*. • *Date clinically ready for discharge* changed to *Date community ready*. Definition has been updated.

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Path

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:

The three inpatient pathways (models of care) are:

Inpatient direct care (Pathway 3):
- Rehabilitation is delivered in an inpatient setting.
- The patient is accommodated overnight in the hospital and included in the bed occupancy reporting at midnight.
- The patient is under the care of the rehabilitation physician who holds the medical governance/bed card.

In-reach (Pathway 2):
- The patient is under the care of an acute physician who holds the medical governance/bed card.
- The rehabilitation physician or team "reaches into" the acute setting to begin the process of rehabilitation in addition to the acute care the inpatient is already receiving.

Consult/Liaison (Pathway 1):
- The patient is under the care of one physician who holds the medical governance/bed card and another physician or team provide a one-off consultation service.

Justification:

N/A

Guide for use:

Select the pathway of care being provided for this episode.

Codeset values:

1	1 - Consult liaison
2	2 - In-reach rehabilitation care
3	3 - Inpatient direct care

Establishment ID

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: A code which represents the facility.

Justification: N/A

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

Ward ID/Team ID

Pathway: 1 ☑ 2 ☑ 3 ☑

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

Justification: 'Ward Identifier' and 'Ward Name' included for those facilities who have more than one ward and wish to:
1. Identify their data at ward/team level
2. Enable assignment of episodes of care to the appropriate ward/team.

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

Ward Name/Team Name

Pathway: 1 ☑ 2 ☑ 3 ☑

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

Justification: 'Ward Identifier' and 'Ward Name' included for those facilities who have more than one ward and wish to:
1. Identify their data at ward/team level.
2. Enable assignment of episodes of care to the appropriate ward/team.

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

Patient Identifier

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	Unique patient identifier established by the facility.
Justification:	N/A
Guide for use:	This is usually the Medical Record Number (MRN) in Australia or National Health Index (NHI) in NZ which is assigned by the hospital/facility.

Letters of Name

Pathway: 1 ☑ 2 ☑ 3 ☑

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 Linkage 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, V4 resources, SLK.

Date of Birth

Pathway: 1 ☑ 2 ☑ 3 ☑

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. For more information on SLK, please refer to the AROC website, V4 resources, SLK.

Date of Birth Estimate

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Flag to indicate if Date of Birth item is a known or estimated value.

Justification: Required as part of the Statistical Linkage Key (SLK) formula used by AROC to link patient's episodes through their rehabilitation journey.

Guide for use: For more information on SLK, please refer to the AROC website, V4 resources, SLK.

Codeset values:

1	Estimated
2	Not estimated

Sex

Pathway: 1 ☑ 2 ☑ 3 ☑

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: N/A

Codeset values:

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

Indigenous Status (AU)

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition: In Australia, 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: N/A

Codeset values:

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

Geographical Residence (AU)

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition: Geographical residence is the state that the patient usually resides in.

Justification: Record the state that the patient usually resides in.

Guide for use: Record the state that the patient usually resides in.

Codeset values:

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

Postcode

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	Postcode is the numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of patient.
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 patient's usual place of residence. Record 8888 for not applicable. Record 9999 for unknown.

Funding Source (AU)

Pathway: 1 ☐ 2 ☐ 3 ☑

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

Justification: Collection of this data item enables AROC to further separate episodes based on who funded the care where the funding source is 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:

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

Health Fund/other payer

Pathway: 1 ☐ 2 ☐ 3 ☑

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

Justification: Collection of this data item enables AROC to further separate episodes based on who funded the care.

Guide for use: Only complete if “funding source” = 2 private health insurance, 4 workers' compensation or 5 motor vehicle third party personal claim.

Codeset values:

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

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

Need for interpreter service?

Pathway: 1 ☐ 2 ☐ 3 ☑

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

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: N/A

Codeset values:

1	Yes - Interpreter needed
2	No - Interpreter not needed

Referral Date

Pathway: 1 ☑ 2 ☑ 3 ☑

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

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.

For example:
An inpatient on the Intensive care ward was thought 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.

Assessment Date

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	Assessment date is the date the patient was first seen by a clinician or the rehabilitation team to assess their appropriateness for rehabilitation care.
Justification:	This item is required to establish time periods between critical points through the rehabilitation episode.
Guide for use:	Current best practice for a clinician is to assess the patient via a face to face meeting with the patient (and/or their significant other/primary carer), and staff currently looking after the patient, and to also undertake a review of clinical records. In some cases, geography or other issues may make a face to face assessment impractical, and in these cases a telephone assessment may be undertaken.

Date clinically ready for rehabilitation care

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	A patient is “clinically ready for rehabilitation” when the rehabilitation physician, or physician with an interest in rehabilitation, deems the patient ready to start their rehabilitation program and have documented this in the patient’s medical record.
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 patient is clinically ready for rehabilitation and not the date rehabilitation actually started.

Was there a delay in episode start?

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: This item identifies whether there was a delay between the patient 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:

1	Yes
2	No

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

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: This item collects information about patient related medical issues that have caused a delay between the patient 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 patient is not medically stable; he was assessed as appropriate for rehabilitation, but can only be admitted once he has been afebrile for 48 hours OR the patient requires further medical examination, investigation or tests, which cannot be provided on the rehabilitation unit.

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 the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Service issues

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: This item collects information about service issues that have caused a delay between the patient 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 of service delays include:
There are no available rehabilitation beds, so the patient 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.

Transport not available to transfer patient from acute hospital to rehabilitation unit 20 km away.

Physician/surgeon in charge of patient's care has not agreed for patient's transfer.

There are waiting lists for access to ambulatory programs.

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 the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - External support issues

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:

This item collects information about external support issues that have caused a delay between the patient 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 patient need to be completed prior to transfer to rehabilitation i.e: patient requires specialist wound management and staff on the rehabilitation unit need to receive this education before the patient can be transferred.

Family delays admission to rehabilitation e.g. the recommended rehabilitation unit is further away from the family home than the acute service, so the family is reluctant to approve the transfer.

Lack of availability of family or friend support e.g. a community based patient needs 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.

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 the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Equipment issues

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: This item collects information about equipment issues that have caused a delay between the patient 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:
Specialist equipment is not available and patient requires specialist bariatric equipment, which the ward needs to hire, prior to admission.

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 the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - Patient behavioural issues

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: This item collects information about patient behavioural issues that have caused a delay between the patient 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 patient is refusing to come to rehabilitation or the patient has challenging behaviours that can not be managed in the rehabilitation unit at this time.

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 the episode start.

Codeset values:

1	Yes
2	No

Episode begin date

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:

Record the date the patient 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 patient.

The begin date for an inpatient, direct, episode of care, is the date that the patient's care is transferred to a rehabilitation physician or physician with an interest in rehabilitation and it's 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 patient is geographically located. This date may be the same as the date the patient was admitted to hospital e.g. Patient admitted from home directly onto the rehabilitation unit OR a date during their hospital stay e.g. Date patient's care was transferred to a rehabilitation physician and rehabilitation commenced whilst the patient remained on the acute ward awaiting a rehabilitation bed.

The begin date for an episode of consultation liaison, is the date an in-patient, under another primary care provider (e.g. Acute care,) was seen by a member of the consult team (e.g. Rehabilitation team) and there is documented evidence in the medical record that the patient meets the criteria for rehabilitation.

Justification:

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

Guide for use:

Record the date that the patient commenced rehabilitation care.

Type of Accommodation prior to this impairment (AU)

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: The type of accommodation the patient lived in prior to the rehabilitation episode of care.

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

Guide for use: Record the patient's accommodation type prior to their current episode of rehabilitation care. The patient's usual accommodation prior to rehabilitation will not necessarily be their usual accommodation after rehabilitation, e.g: the patient may have come from a private residence and be discharged to a nursing home.

Codeset values:

1	Private residence (including unit in retirement village)
2	Residential, low level care (hostel)
3	Residential, high level care (nursing home)
4	Community group home
5	Boarding house
6	Transitional living unit
8	Other

Carer status prior to this impairment

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the level of carer support the patient received prior to their current inpatient admission. Include both paid and/or unpaid carer support received. Paid carer support includes both government funded and private health funded carers. Unpaid carer support include care provided by a relative, friend, partner of the patient.

Justification: Carer status is a key outcome measure for rehabilitation. Carer status before and after rehabilitation can be compared as a indication of patient's rehabilitation outcomes.

Guide for use: Only complete if the patient's type of accommodation prior was private residence (including unit in retirement village), otherwise leave blank.

Include both paid and unpaid carer support.
Example of paid carer support: Mrs Jackson has a paid carer who comes to her home and assist her with personal care in the morning and the evening.
Example of unpaid carer support: Mr Price's daughter completes his weekly grocery shop for him as he is no longer able to drive.

Within the code set, "Co-dependent" is when the carer and a patient depend on each other for assistance with functional tasks. For example Mr Jones receives assistance from his wife to cut up his food and Mrs Jones receives assistance from her husband to remember to take her medication.

Codeset values:

1	NO CARER and DOES NOT need one
2	NO CARER and NEEDS one
3	CARER NOT living in
4	CARER living in, NOT co-dependent
5	CARER living in, co-dependent

Were any services being received within the month prior to this impairment?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

This item identifies whether services were received by the person prior to this impairment. “Services” refers to paid or unpaid services received in the month prior to this impairment (or exacerbation of impairment). Paid service(s) include both government funded and private health funded services. Unpaid service(s) include care provided by a relative, friend,or partner of the patient. Discretionary services received by the patient, but not functionally necessary, should not be included e.g. A house cleaner because the patient doesn’t like cleaning rather than functionally can’t clean.

Justification:

Service(s) received relates to degree of functional independence of the person, and as increased functional independence is a key outcome measure for rehabilitation, it is important to ascertain the person's level of functional independence prior to rehabilitation. Service(s) received before and after rehabilitation can be compared as a indication of any change in the person's functional independence after rehabilitation.

Guide for use:

Only collect this data item if accommodation prior to this impairment was private residence (including unit in retirement village,) otherwise leave blank.

Record 1,”Yes,” if service(s) were received and 2,”No,’ if no service(s) were received in the month prior to this impairment (or exacerbation of impairment).

Codeset values:

1	Yes
2	No

Services received prior to impairment

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

This item collects information about whether the patient received paid or unpaid assistance in the month prior to their impairment.

Justification:

The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use:

Only collect this data item if the patient received any paid or unpaid assistance. Record 1, "Yes" if they received assistance and 2, "No" if they did not receive assistance (paid or unpaid). Unpaid assistance is when a service is provided by a relative, friend or partner. Discretionary services received by the patient, but not functionally necessary, should not be included e.g. a house cleaner because the patient doesn't like cleaning rather than functionally can't clean.

Domestic tasks include: household cleaning, vacuuming, ironing, shopping, managing finances and meal preparation. Paid domestic assistance service(s) include both government funded and private health funded services.

Social support includes: daily wellbeing through telephone calls, medication reminders, counselling etc. Paid social support service(s) include both government funded and private health funded services.

Nursing care includes: nurse visiting a patient to administer wound care, medication, manage incontinence etc. Paid nursing care includes both government funded and private health funded services.

Allied health care includes: provision of physiotherapy, occupational therapy, speech and language therapy, recreational therapy, social work, psychology etc. Paid allied health care include both government funded and private health funded services.

Personal care includes: washing, dressing, grooming, eating, toileting etc. Paid personal care service(s) include both government funded and private health funded services.

Meals include: ready meals such as meals on wheels or lite and easy meals etc. Paid meal service(s) include both government funded and private health funded meal services.

Goods and equipment include: specialised equipment e.g. shower chair, commode, hoist, wheelchair OR smaller aids e.g. plate guard for eating, adapted cutlery, long handled sponge for washing etc. Paid goods and equipment include both government funded and private health funded goods and equipment.

Transport services include: community transport for shopping or attending medical appointments, taxi vouchers, community bus and/or use of patient transport assistance vehicle etc. Paid transport service(s) include both government funded and private health funded services.

Case management may be defined as a service that provides assessment, planning, facilitation and advocacy for options and services to meet a patients needs. Paid case management includes both government funded and private health funded case management services.

Data Items:

Service received prior to impairment - Domestic assistance
Service received prior to impairment - Social support
Service received prior to impairment - Nursing care
Service received prior to impairment - Allied health care
Service received prior to impairment - Personal care
Service received prior to impairment - Meals
Service received prior to impairment - Provision of goods & equipment
Service received prior to impairment - Transport services
Service received prior to impairment - Case management

Codeset values:

1	Yes
2	No

Employment status prior to this impairment

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition:

This item records the patient's employment status before they had their impairment (or exacerbation of impairment).

Justification:

Employment is an important outcome that can be measured through the patient's rehabilitation journey. Employment status prior to this impairment is collected as a baseline measure and can be used to group patients into "similar" cohorts for analysis. Employed patients are flagged on admission and their employment status, or potential, is re-assessed at discharge enabling a measure of change.

Guide for use:

Record the patient's employment status before they had their impairment (or exacerbation of impairment).

Within the codeset:
Employment includes patients who performed work for wages or salary, in cash or in kind (including self employed and volunteers). It also includes patients temporarily absent from a paid employment, but who retained a formal attachment to that job, e.g. unpaid maternity leave.

Unemployed includes patients who are without a job or out of work, usually involuntarily.

Student/child includes patients who are enrolled, either full-time or part-time, in an accredited teaching institution providing instruction.

Not in the labour force includes patients who have left the labour force e.g. retired by choice, mothers choosing to stay at home and care for children.

Retired for age includes patients who have left the workforce due to their age and do not intend on recturning to paid work in any capacity.

Retired for disability includes patients who have left the workforce due to a disability which is preventing them from working.

Codeset values:

1	Employed
2	Unemployed
3	Student
4	Not in labour force
5	Retired for age
6	Retired for disability

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

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition:

This item relates to the patient's impairment and setting, not the particular facility. "Direct care" is when the patient is under the direct care of the rehabilitation physician or team, i.e. they hold medical governance over the patient. An episode of direct care can be provided in the inpatient rehabilitation setting or ambulatory rehabilitation setting (e.g. outpatient and/ or community).

The first direct care rehabilitation episode for this impairment considers only those episodes occurring in this setting regardless of facility i.e. it aims to identify those patients that have repeated rehabilitation admissions/discharges within the one setting as subsequent episodes are typically quite different to primary episodes (NOTE: subsequent episodes caused by adhering to any required jurisdictional business rules will be concatenated into one primary episode as long as they occur within the same facility).

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

Justification:

This item attempts to differentiate the patient's first direct care rehabilitation episode (within a setting) from subsequent episodes through the patient'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:

INPATIENT ONLY: A patient who had a Stroke, has an episode of acute care and is then transferred to an inpatient rehabilitation program. This is the first direct rehabilitation episode of care they have received for their stroke in the inpatient setting — record 1=Yes.

INPATIENT FOLLOWING IN-REACH: A patient who has had a stroke, received in-reach rehabilitation prior to being admitted for inpatient rehabilitation. While the inpatient rehabilitation episode is NOT their first direct rehabilitation episode for this stroke, it is the first direct rehabilitation episode of care in the inpatient rehabilitation setting — record 1=Yes.

INPATIENT FOLLOWING SUSPENSION: A patient receiving inpatient rehabilitation for reconditioning was admitted back to acute care for a period and has now returned to inpatient rehabilitation for the same condition as before. This inpatient rehabilitation episode is NOT their first direct rehabilitation episode for reconditioning in the inpatient rehabilitation setting — record 2=No.

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

SPECIALIST INPATIENT FOLLOWING IN-REACH/GENERAL INPATIENT: A patient with a brain injury (or spinal cord injury) is transferred to a specialist brain injury unit (spinal cord injury unit) for inpatient rehabilitation having received rehabilitation elsewhere (e.g. in-reach rehabilitation on an acute ward or inpatient rehabilitation on a general rehabilitation ward while waiting specialist unit placement). While the inpatient rehabilitation episode is NOT their first direct rehabilitation episode for this impairment as a rehabilitation inpatient, it is the first direct rehabilitation episode of care in the specialist inpatient setting — record 1=Yes.

SPECIALIST INPATIENT FOLLOWING SPECIALIST INPATIENT: a patient with an acquired brain injury was admitted for a boost of inpatient rehabilitation care relating to the original brain injury for which they received their first direct episode of rehabilitation care on the inpatient brain injury ward 12 months prior. This is not the first direct rehabilitation episode of care in the specialist inpatient setting for this impairment — record 2=No.

Codeset values:

1	Yes
2	No

Date multi-disciplinary team rehabilitation plan established

Pathway: 1 ☐ 2 ☑ 3 ☑

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 multi-disciplinary consultation and consultation with the patient. 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 is required for collection and calculation of the version 4 ACHS Rehabilitation Medicine clinical indicators; reflects timely establishment of a multi-disciplinary team rehabilitation plan.

Guide for use: Record the date the multidisciplinary team rehabilitation plan is formally documented in the patient's medical record. It must be a record of the plan formulated by the team on initial assessment of the patient. Often, the initial case conference document is a formal multidisciplinary plan for the patients care while participating in rehabilitation. In other cases, the patient 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 of injury/impairment onset

Pathway: 1 ☐ 2 ☐ 3 ☑

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 patient fractured their hip, the date the patient had a stroke, or the date the patient had a limb amputated.
Justification:	This item is being collected to be able 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.

Time since onset or acute exacerbation of chronic condition

Pathway: 1 ☐ 2 ☐ 3 ☑

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

Justification: It is thought that the time between the onset of the impairment (or exacerbation) and admission to a rehabilitation program affects FIM improvement, and the patient's length of stay in the hospital. This AROC item provides data which may help support this theory.

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

In some cases, the impairment that has driven the need for rehabilitation may be a chronic disease with an insidious onset, and in these cases, record when the impairment started affecting the patient's function. For example, a patient admitted for rehabilitation for arthritis – no relevant acute admission – where the arthritis flared up 6 months ago and started affecting the patient's functioning, record codeset "6 months to less than 1 year".

Codeset values:

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

Date of relevant acute episode

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition: Record the date of the acute admission relevant to the current episode of rehabilitation.

Justification: This item is being collected to enable calculation of the time between acute admission and rehabilitation start dates, and analysed against outcomes achieved.

Guide for use: Only collect this data item if the current episode for rehabilitation care was preceded by an episode of acute care, in the previous three months, relevant to the current rehabilitation episode.

For example, A patient falls, fractures their hip and is admitted to an acute hospital on 01/02/2012. Once medically stable, the patient is transferred to the rehabilitation ward. Record 01/02/2012, the date of the relevant acute admission for this impairment. A patient may have required multiple hospital admissions for the one acute condition, such as a recurrent subdural haematoma bleed, or an infection post knee or hip replacement. In such cases, record the date of acute admission immediately post impairment. At times, this date may be the same as Date of Injury/Impairment Onset.

Mode of Episode Start - Inpatient

Pathway: 1 ☐ 2 ☑ 3 ☑

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

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

Guide for use: Patients can be admitted from the community, either directly from their home (usual accommodation; could be private residence or a nursing home), or from somewhere other than their usual accommodation (staying with friends). The other major option is that person is admitted from a hospital setting.

Within the code set,
"Usual accommodation" may be defined as the patient's regular fixed abode e.g. their own home/rented residence or residential care home.

"Other than usual accommodation" may be defined as temporary accommodation e.g. patient was away on holiday or business or visiting family and friends when he suffered his injury and was admitted to hospital.

"Acute specialist unit" may be defined as a medical unit resourced with highly trained and experienced staff in the management of a specific diagnosis or impairment. The unit will also be resourced with any specialist equipment required. For e.g. ICU (intensive care unit) has nurses trained in critical care and life support equipment. An acute stroke unit has a multi-disciplinary team of clinicians highly experienced and trained in stroke management and resourced with equipment to provide specialist stroke care.

Codeset values:

1	Admitted from usual accommodation
2	Admitted from other than usual accommodation
3	Transferred from another hospital
4	Transferred from acute care in another ward
5	Transferred from acute specialist unit
6	Change from acute care to sub/non acute care whilst remaining on same ward
7	Change of sub/non acute care type
8	Other
9	Recommenced rehabilitation episode following suspension

AROC Impairment Code

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: The AROC Impairment codes are used to classify rehabilitation episodes into like clinical groups. The Australian codes are based on the Uniform Data System for Medical Rehabilitation (UDSMR) codes. The selected code should reflect the primary reason for the current episode of rehabilitation care.

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

Guide for use: The AROC Impairment Coding Guidelines 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.

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

Codeset values:

1.11	Stroke, Haemorrhagic, Left Body Involvement (Right Brain)
1.12	Stroke, Haemorrhagic, Right Body Involvement (Left Brain)
1.13	Stroke, Haemorrhagic, Bilateral Involvement
1.14	Stroke, Haemorrhagic, No Paresis
1.19	Other haemorrhagic stroke
1.21	Stroke, Ischaemic, Left Body Involvement (Right Brain)
1.22	Stroke, Ischaemic, Right Body Involvement (Left Brain)
1.23	Stroke, Ischaemic, Bilateral Involvement
1.24	Stroke, Ischaemic, No Paresis
1.29	Other ischaemic stroke
2.11	Brain Dysfunction, Non traumatic, subarachnoid haemorrhage
2.12	Brain Dysfunction, Non traumatic, Anoxic brain damage
2.13	Other non-traumatic brain dysfunction
2.21	Brain Dysfunction, Traumatic, open injury
2.22	Brain Dysfunction, Traumatic, closed injury
3.1	Neurological conditions, Multiple sclerosis
3.2	Neurological conditions, Parkinsonism
3.3	Neurological conditions, Polyneuropathy
3.4	Neurological conditions, Guillian-Barre
3.5	Neurological conditions, Cerebral palsy
3.8	Neurological conditions, Neuromuscular disorders
3.9	Other neurological conditions
4.111	Spinal Cord Dysfunction, Non-traumatic, Paraplegia, incomplete
4.112	Spinal Cord Dysfunction, Non-traumatic, Paraplegia, complete
4.1211	Spinal Cord Dysfunction, Non-traumatic, Quadriplegia incomplete C1-4
4.1212	Spinal Cord Dysfunction, Non-traumatic, Quadriplegia incomplete C5-8
4.1221	Spinal Cord Dysfunction, Non-traumatic, Quadriplegia complete C1-4
4.1222	Spinal Cord Dysfunction, Non-traumatic, Quadriplegia complete C5-8
4.13	Other non-traumatic spinal cord dysfunction
4.211	Spinal Cord Dysfunction, Traumatic, Paraplegia, incomplete
4.212	Spinal Cord Dysfunction, Traumatic, Paraplegia, complete
4.2211	Spinal Cord Dysfunction, Traumatic, Quadriplegia incomplete C1-4

4.2212	Spinal Cord Dysfunction, Traumatic, Quadriplegia incomplete C5-8
4.2221	Spinal Cord Dysfunction, Traumatic, Quadriplegia complete C1-4
4.2222	Spinal Cord Dysfunction, Traumatic, Quadriplegia complete C5-8
4.23	Other traumatic spinal cord dysfunction
5.11	Amputation of Limb, Non traumatic, Single upper amputation above the elbow
5.12	Amputation of Limb, Non traumatic, Single upper amputation below the elbow
5.13	Amputation of Limb, Non traumatic, Single lower amputation above the knee
5.14	Amputation of Limb, Non traumatic, Single lower amputation below the knee
5.15	Amputation of Limb, Non traumatic, Double lower amputation above the knee
5.16	Amputation of Limb, Non traumatic, Double lower amputation above/below the knee
5.17	Amputation of Limb, Non traumatic, Double lower amputation below the knee
5.18	Amputation of Limb, Non traumatic, Partial foot amputation (includes single/double)
5.19	Other non-traumatic amputation
5.21	Amputation of Limb, Traumatic, Single upper I amputation above the elbow
5.22	Amputation of Limb, Traumatic, Single upper amputation below the elbow
5.23	Amputation of Limb, Traumatic, Single lower amputation above the knee
5.24	Amputation of Limb, Traumatic, Single lower amputation below the knee
5.25	Amputation of Limb, Traumatic, Double lower amputation above the knee
5.26	Amputation of Limb, Traumatic, Double lower amputation above/below the knee
5.27	Amputation of Limb, Traumatic, Double lower amputation below the knee
5.28	Amputation of Limb, Traumatic, Partial foot amputation (includes single/double)
5.29	Other traumatic amputation
6.1	Arthritis, Rheumatoid arthritis
6.2	Arthritis, Osteoarthritis
6.9	Other arthritis
7.1	Pain, Neck pain
7.2	Pain, Back pain
7.3	Pain, Extremity pain
7.4	Pain, Headache (includes migraine)
7.5	Pain, Multi-site pain
7.9	Other pain
8.111	Orthopaedic Conditions, Fracture of hip, unilateral (includes #NOF)
8.112	Orthopaedic Conditions, Fracture of hip, bilateral (includes #NOF)
8.12	Orthopaedic Conditions, Fracture of shaft of femur (excludes femur involving knee joint)
8.13	Orthopaedic Conditions, Fracture of pelvis
8.141	Orthopaedic Conditions, Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
8.142	Orthopaedic Conditions, Fracture of leg, ankle, foot
8.15	Orthopaedic Conditions, Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
8.16	Orthopaedic Conditions, Fracture of spine (excludes where the major disorder is pain)
8.17	Orthopaedic Conditions, Fracture of multiple sites
8.19	Other orthopaedic fracture
8.211	Post orthopaedic surgery, Unilateral hip replacement
8.212	Post orthopaedic surgery, Bilateral hip replacement
8.221	Post orthopaedic surgery, Unilateral knee replacement
8.222	Post orthopaedic surgery, Bilateral knee replacement
8.231	Post orthopaedic surgery, Knee and hip replacement same side
8.232	Post orthopaedic surgery, Knee and hip replacement different sides
8.24	Post orthopaedic surgery, Shoulder replacement or repair
8.25	Post orthopaedic surgery, Post spinal surgery
8.26	Other orthopaedic surgery
8.3	Soft tissue injury
9.1	Cardiac, Following recent onset of new cardiac impairment

9.2	Cardiac, Chronic cardiac insufficiency
9.3	Cardiac, Heart or heart/lung transplant
10.1	Pulmonary, Chronic obstructive pulmonary disease
10.2	Pulmonary, Lung transplant
10.9	Other pulmonary
11	Burns
12.1	Congenital Deformities, Spina bifida
12.9	Other congenital
13.1	Other Disabling Impairments, Lymphoedema
13.3	Other Disabling Impairments, Conversion disorder
13.9	Other disabling impairments. This classification should rarely be used.
14.1	Major Multiple Trauma, Brain + spinal cord injury
14.2	Major Multiple Trauma, Brain + multiple fracture/amputation
14.3	Major Multiple Trauma, Spinal cord + multiple fracture/ amputation
14.9	Other multiple trauma
15.1	Developmental disabilities
16.1	Re-conditioning following surgery
16.2	Re-conditioning following medical illness
16.3	Cancer rehabilitation

Date episode start FIM assessed

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	Record the date that the patient's admission Functional Independence Measure (FIM instrument) scores were completed.
Justification:	This item is required for collection and calculation of the version 4 ACHS Rehabilitation Medicine clinical indicators. It reflects timely assessment of function on admission.
Guide for use:	Admission FIM scoring needs to be completed as soon as possible after patient admission to inpatient rehabilitation. Assessment is complete when the last item of the FIM 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 FIM assessment was completed, the date recorded must be the date the last item of the FIM assessment was scored.

Admission FIM Scores

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the patient's Functional Independence Measure (FIM) score for each of the 18 FIM items, assessed at the time of admission. This item is mandatory for the inpatient data collection.

Justification: The Functional Independence Measure (FIM instrument) scores and the AROC Impairment codes are based on the Uniform Data System for Medical Rehabilitation (UDSMR); a minimum data set that includes a system for grouping rehabilitation episodes by impairment type and a rating scale to measure function, the FIM instrument. The FIM instrument is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM instrument is used to track those changes which are a key outcome measure of rehabilitation episodes. Thus the AROC inpatient dataset collects FIM scores at episode start and episode end.

Guide for use: Admission FIM scoring needs to be completed as soon as possible after admission to establish an appropriate baseline functional score.

Data Items:

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

Codeset values:

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

Employment status after, or anticipated employment status after discharge

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition: Record the patient's employment status, or anticipated employment status, after discharge.

Justification: Employment is an important outcome that can be measured through the patient's rehabilitation journey. If the patient was employed prior to this impairment, AROC is interested in knowing if their rehabilitation has enabled them to achieve a level of function that allows them to return to work or not. If they have, AROC is also interested in knowing to what level they are able to return to work.

Collection of this data will enable analysis of employment outcome achievement. For example, a patient was employed prior to admission and returned to their same or similar job, with reduced hours upon discharge may have different functional outcomes to a patient was employed prior to their admission, but is unable to work upon discharge.

Guide for use: Only complete this item if the patient was employed prior to this impairment (or exacerbation of this impairment). Record the patient's employment status, or anticipated employment status, after discharge. This is a new item in the v4 dataset.

Codeset values:

1	Same or similar job, same or similar hours
2	Same or similar job, reduced hours
3	Different job by choice
4	Different job due to reduced function
5	Not able to work
6	Chosen to retire
7	Too early to determine

Date episode end FIM assessed

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:	Record the date the patient's discharge FIM scores were scored.
Justification:	This item is required for collection and calculation of the version 4 ACHS Rehabilitation Medicine clinical indicators. Collection time stamps assessment of function prior to patient episode end.
Guide for use:	Discharge FIM scoring needs to be completed before the patient is discharged from the rehabilitation program, ideally as close as possible PRIOR to discharge. Assessment is complete when the last item of the FIM 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 FIM assessment was completed, the date recorded must be the date the last item of the FIM assessment was scored.

Discharge FIM scores

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the patient's Functional Independence Measure (FIM) score for each of the 18 FIM items, assessed at the time of discharge. This item is mandatory for the inpatient data collection.

Justification: The Functional Independence Measure (FIM instrument) scores and the AROC Impairment codes are based on the Uniform Data System for Medical Rehabilitation (UDSMR); a minimum data set that includes a system for grouping rehabilitation episodes by impairment type and a rating scale to measure function, the FIM instrument. The FIM instrument is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM instrument is used to track those changes which are a key outcome measure of rehabilitation episodes. Thus the AROC inpatient dataset collects FIM scores at episode start and episode end.

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

Data Items:

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

Codeset values:

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

Community ready date

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

A patient should be defined as ready to be discharged to the community (Community Ready) when:

•The patient no longer requires the intensity of therapy provided by an inpatient rehab service. For example, further rehab could be provided in an ambulatory setting if available

•The patient has achieved a level of function that allows them to be safely discharged to the community based on their dwelling/social/geographical/financial status. For example, does the patient need to be able to manage 2 stairs/or require home modifications prior to discharge: does the patient lives in a location where ambulatory services are not available and has no transport to attend an ambulatory service located in another location and therefore requires further rehabilitation in an inpatient rehab service to be deemed safe to return to the community

•The patient's level of function is stable enough to enable prediction of long term support needs (if required)

•The patient is medically stable (including comorbidities) and can be managed in the community by a GP

•The reason the patient is still in inpatient rehabilitation care is beyond the control of the rehab team. For example, the patient is awaiting the outcome of an NDIS application, or home modifications are required to be completed, or the patient is awaiting services to be put in place.

Justification:

Anecdotally the date a patient is deemed community ready is not always the same as the actual discharge date. At times, there are delays. This item is being 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 patient was deemed community ready, not the date the patient was actually discharged. In some cases, these dates may vary due to a delay.

Collection is mandatory if E114, Mode of Episode End= 1 or 2, otherwise completion is optional.

Was there a delay in discharge?

Pathway: 1 ☐ 2 ☑ 3 ☑

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 5 questions about reason(s) for delay in discharge.

Codeset values:

1	Yes
2	No

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

Pathway: 1 ☐ 2 ☑ 3 ☑

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

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:
Patient becomes medically unstable just before discharge and remains in the hospital for medical treatment not available in the community, e.g. patient develops an UTI and becomes confused or patient falls just prior to discharge.

Patient suddenly requires an intervention that needs to be completed prior to returning home e.g. an additional x-ray or ultrasound.

A non-weight bearing patient no longer requires inpatient rehabilitation and is unable to return to the community as no alternative care facility is available.

If you would like to provide additional information, please use the general comments section. Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Service issues

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: This item collects information about service 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 service issues.

Guide for use:

Examples include:
Patient requires residential care placement, but there are no available beds.

Patient requires low level care placement (hostel) and there are no beds available.

Transport not available to transfer patient from rehabilitation unit to discharge destination.

Patient requires OT home visit to confirm safe access and internal environment before discharge, but there are no OTs available.

Waiting specialist review prior to discharge e.g. patient requires specialist review of weight-bearing status.

Waiting aged care assessment to access and sign off on level of care patient will require upon discharge.

Patient requires service(s) to ensure safe discharge and the necessary services are not available e.g. carer unavailable, domiciliary nursing care unavailable.

Patient requires ambulatory rehabilitation services, however there is a waiting list. The inpatient team feel that patient can not be discharged until ambulatory rehabilitation is confirmed.

If you would like to provide additional information, please use the general comments section. Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - External support issues

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: This item collects information about external support 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 external support issues.

Guide for use: Examples include:
Education to carer or family about clinical needs of patient need to be completed to ensure safe discharge and carer or family member not available until after set discharge date.

Family delays discharge e.g. family thinks patient would benefit from further inpatient rehabilitation or medical team continue to negotiate with family regarding care they can provide or discharge destination.

Lack of availability of family or friend to support patient upon discharge e.g. patient lives with family or friend and is unsafe to live alone. Family or friend will be out of town at time of discharge.

Accommodation e.g. patient has no available accommodation to be discharge to, patient is homeless.

If you would like to provide additional information, please use the general comments section. Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Equipment issues

Pathway: 1 ☐ 2 ☑ 3 ☑

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:
Major or minor home modifications required for safe discharge are not complete.

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

If you would like to provide additional information, please use the general comments section. Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Reason for delay in discharge - Patient behavioural issues

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: This item collects information about patient behavioural 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 patient behavioural issues

Guide for use: Examples include:
The patient is refusing to be discharged.

If you would like to provide additional information, please use the general comments section. Leave blank if you indicated that there was no delay in discharge.

Codeset values:

1	Yes
2	No

Is there an existing comorbidity interfering with this episode

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:

This item identifies whether the patient had any other significant existing illness/impairment, not part of the principal presenting condition, which interfered with the process of rehabilitation.

Justification:

It is important to identify whether the patient 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 patient’s rehabilitation program was affected by the comorbidity, otherwise answer 2, “No”.

The effect of the comorbidity should be apparent in the patient’s medical record, for example:
The patient required extensive medication management for diabetes and had variability in blood sugar levels during the admission that affected their ability to participate.

The patient required a longer length of stay to accommodate fatigue after dialysis.

The patient had one or more epileptic fits that caused the patient 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 patient’s rehabilitation, it is highly likely a suspension of treatment may also have occurred and would need to be recorded.

Codeset values:

1	Yes
2	No

Comorbidity Items

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Comorbidities interferring with the rehabiliation episode (up to four can be selected).

Justification: It is important to identify whether the patient had comorbidities and which ones, as investigation of such data may reflect a relationship between the presence of a particular comorbidity, the rehabilitation outcome and length of stay.

Guide for use: If there is an existing comorbidity interfering with this episode indicated then at least one, and up to four comorbidities must be recorded.

Data Items:

Comorbidities Interfering with Rehabilitation Episode (1)
Comorbidities Interfering with Rehabilitation Episode (2)
Comorbidities Interfering with Rehabilitation Episode (3)
Comorbidities Interfering with Rehabilitation Episode (4)

Codeset values:

1	Cardiac disease
2	Respiratory disease
3	Drug and alcohol abuse
4	Dementia
5	Delirium, pre-existing
6	Mental health problem
7	Renal failure with dialysis
8	Renal failure NO dialysis
9	Epilepsy
10	Parkinsons disease
11	Stroke
12	Spinal cord injury/disease
13	Brain injury
14	Multiple sclerosis
15	Hearing impairment
16	Diabetes mellitus
17	Morbid obesity
18	Inflammatory arthritis
19	Osteoarthritis
20	Osteoporosis
21	Chronic pain
22	Cancer
23	Pressure ulcer, pre-existing
24	Visual impairment
99	Other

Were there any complications interfering with this episode?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

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

Justification:

It is important to identify whether the patient 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 patient’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 spinal patient on bed rest developed a pressure ulcer which prevented him from engaging at the anticipated intensity in his planned rehabilitation program.

A patient developed a UTI, became confused 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 patient’s rehabilitation, it is highly likely a suspension of treatment may also have occurred and would need to be recorded.

Codeset values:

1	Yes
2	No

Complication Items

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Complications interferring with the rehabiliation episode (up to four can be selected).

Justification: It is important to identify whether the patient had any complications and which ones, as investigation of such data may reflect a relationship between the presence of a particular complication, the rehabilitation outcome and length of stay.

Guide for use: If there is an existing complication interfering with this episode indicated then at least one, and up to four, complications must be recorded.

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:

1	UTI
2	Incontinence faecal
3	Incontinence urinary
4	Delirium
5	Fracture
6	Pressure ulcer
7	Wound infection
8	DVT/PE
9	Chest infection
10	Significant electrolyte imbalance
11	Fall
12	Faecal impaction
99	Other

Episode end date

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:

Record the date that the patient 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.

Inpatient rehabilitation episode ends when the patient is discharged from the rehabilitation unit and/or the care type is changed from rehabilitation to acute or some other form of sub-acute (maintenance/ palliative care) no matter where the patient is physically located (rehabilitation ward/ acute ward).

The end date for a consultation liaison episode of rehabilitation is when the patient is discharged by the rehabilitation physician or team completing the one-off consultation, no matter where the patient is physically located (rehabilitation ward/ acute ward). A consultation begin and end date may be the same at times.

Justification:

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

Guide for use:

Record the date that the patient completes their rehabilitation episode, or when the patient is discharged at their own risk.

Mode of episode end (Inpatient)

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

This item records data about where the patient went to at the end of their in-patient rehabilitation episode.

There are two broad categories reflecting where the patient can go:
1. Back to the community
2. Remain in the hospital system.

Where the patient has a care type change, pathway 2 (In-reach) patients care type change will be from acute care to sub-acute care while inpatient - pathway 3 (Inpatient) patients care type change will be from sub-acute care to acute care.

Justification:

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

Guide for use:

Patients can be discharged to the community, either directly to their final destination and what will be their home from now on (could be private residence or a nursing home), or to an interim destination.

Where the patient has a care type change, pathway 2 (In-reach) patients care type change will be from acute care to sub-acute care while pathway 3 (Inpatient) patients care type change will be from sub-acute care to acute care. The other major option is that person is discharged back to a hospital setting.

If patient is discharged to their final destination, provide final destination details under data item, "final destination." If patient 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 and unspecified" as this contributes to nonspecific data. If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Discharged to final destination
2	Discharged to interim destination
3	Death
4	Discharged/transferred to other hospital
5	Care type change and transferred to a different ward
6	Care type change and remained on same ward
7	Change of care type within sub/non acute care
8	Discharged at own risk
9	Other and unspecified

Interim destination (AU)

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

This and the next item collect the type of accommodation a patient is going to 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 patient 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 patients discharge, or the lack of equipment and/or services available to the patient.

Guide for use:

Interim accommodation acknowledges that the patient has not been able to return to the most ideal 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. Interim destination is about intentions, not time frames.

For example:
Mrs Jones was discharged to her local country hospital (as maintenance patient, interim accommodation) whilst awaiting approval for a care package to be set-up in her own home (final accommodation).

Mr Major was discharged to his daughter's home (interim accommodation) whilst awaiting completion of home modifications to his own 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.

Codeset values:

1	Private residence (including unit in retirement village)
2	Residential, low level care(hostel)
3	Residential, high level care(nursing home)
4	Community group home
5	Boarding house
6	Transitional living unit
7	Hospital
8	Other
9	Unknown

Final destination (AU)

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Final destination may be defined as the accommodation that a patient is discharged to that is the most appropriate long term accommodation for the patient.

Justification: Type of accommodation before, during and after rehabilitation treatment are collected to reflect and compare where the patient 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. Please carefully consider the use of the code set value '9, Unknown' as this contributes to non-specific data.

Codeset values:

1	Private residence (including unit in retirement village)
2	Residential, low level care(hostel)
3	Residential, high level care(nursing home)
4	Community group home
5	Boarding house
6	Transitional living unit
8	Other
9	Unknown

Carer status post discharge

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the level of carer support the patient receives post discharge from their inpatient or ambulatory rehabilitation episode of care. Include both paid and/or unpaid carers. Paid carer support includes both government funded and private health funded carers. Unpaid carer support include care provided by a relative, friend, partner of the patient.

Justification: Carer status is a key outcome measure for rehabilitation. Carer status before and after rehabilitation can be compared as a indication of patient's rehabilitation outcomes.

Guide for use: Only record if "final destination" or "interim destination" was private residence (including unit in retirement village), otherwise leave blank. Include both paid and unpaid carer support.

Example of paid carer support: Mrs Jackson will have a paid carer come to her home and assist her with personal care in the morning and the evenings post discharge.

Example of unpaid carer support: Mr Price's daughter will complete his weekly grocery shop for him as he is no longer able to drive.

Within the code set, "co-dependent" is when the carer and a patient depend on each other for assistance with functional tasks. For example Mr Jones will receive assistance from his wife to cut up his food and Mrs Jones will receive assistance from her husband to remember to take her medication.

Codeset values:

1	NO CARER and DOES NOT need one
2	NO CARER and NEEDS one
3	CARER NOT living in
4	CARER living in, NOT co-dependent
5	CARER living in, co-dependent

Total number of days seen

Pathway: 1 ☑ 2 ☐ 3 ☐

Definition:	The total number of days that service(s) were provided to the patient during their episode of care.
Justification:	This item enables an accurate count of the total number of ACTUAL days the patient received therapy during their rehabilitation episode of care, which may impact on patient outcomes.
Guide for use:	In the inpatient setting, this item is only collected for inpatients who are seen once for a one off assessment (consult liaison), for example, when a 'second opinion', advice on a particular problem, a case review, a one-off assessment or therapy session is required. In such cases, the patient has been seen once, so you would record “total number of days seen” as 1.

Total number of occasions of service

Pathway: 1 ☑ 2 ☐ 3 ☐

Definition:	The total number of occasions of service to the patient. An occasion of service may be defined as each time therapy is provided to the patient; one therapy provider may provide an occasion of service to one or many patients at the same time (individual vs. group therapy). A patient may receive a number of occasions of service on the same day (e.g., physiotherapy in the morning and speech pathology in the afternoon).
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 inpatient setting, this item is only collected for inpatients who are seen once for a one off assessment (consult liaison), for example, when a 'second opinion', advice on a particular problem, a case review, or a one-off assessment or therapy session is required. In such cases, the patient has been seen once, so you would record “occasions of service” as 1.

Disciplines involved in therapy

Pathway: 1 ☑ 2 ☐ 3 ☐

Definition: Record the type(s) of health professional or other care provider who provided treatment to the patient during their rehabilitation episode of care, as represented by a code.

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 patient during this episode of care. Choose up to 10. Please indicate hydrotherapist as the staff type even if the hydrotherapy was provided by a physiotherapist. Similarly, please indicate exercise physiologist/remedial gymnast as the staff type even if the gym class is overseen by a physiotherapist.

Data Items:

Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care
Staff type providing therapy during episode of care

Codeset values:

1	Aboriginal Liaison Worker
2	Audiologist
3	Case Manager
4	Clinical Nurse Consultant
5	Clinical Nurse Specialist
6	Community support worker
7	Dietitian
8	Enrolled nurse
9	Exercise physiologist / Remedial Gymnast
10	Educational tutor
11	Hydrotherapist
12	Interpreter
13	Medical Officer
14	Nurse Practitioner
15	Neuro-psychologist
16	Occupational Therapist
17	Physiotherapist
18	Podiatrist
19	Psychologist
20	Registered Nurse
21	Recreational Therapist
22	Speech Pathologist
23	Social Worker
24	Therapy Aide
25	Vocational Co-ordinator
98	Other

Total number of leave days

Pathway: 1 ☐ 2 ☐ 3 ☑

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

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). Do not leave this item blank.
Example: Mrs Jones is nearing the end of her rehabilitation episode. It has been decided that Mrs Jones will go home for two days on trial leave, to see if she is able to cope. Mrs Jones copes quite well, 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 patients rehabilitation.
Example: A month before his discharge, Mr Smith trialled an overnight stay at his own home. It was successful, so 2 nights weekend leave were arranged for the remaining 3 weeks of his rehabilitation episode. Total leave days = 1+2+2+2= 7 days.

Total number of suspension days

Pathway: 1 ☐ 2 ☐ 3 ☑

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 patient'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 patient participating in their rehabilitation program. For example, a flare up of asthma where the patient develops breathing problems and therefore cannot participate in their rehabilitation program for a period of time. During the period of suspension the patient 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 (eg. Gastroscopy, renal dialysis) that prevents the patient participating in their rehabilitation program for a period of time. The patient may need to be transferred to another facility for this procedure.

3. The requirement for the patient to attend a medical appointment that prevents the patient participating in their rehabilitation program for a period of time.

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

Please note that where a patient participates in their rehabilitation program in the morning and then has, for example, their renal dialysis in the afternoon, this IS NOT a suspension of treatment, because the patient has participated in their program on that day.

Please note that where a patient 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 where a patient's rehabilitation treatment is suspended for a period, and the patient then comes back onto the same program of rehabilitation (that is, a new program is not required to be developed), then 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 patient comes back onto the same program of rehabilitation.

For example: Mrs Jones is admitted on Monday and commences treatment straight away. On Thursday her asthma flares up and she is unable to undertake her rehabilitation program on Thursday and Friday. She starts again on Saturday. Next Wednesday her asthma flares up again and she does not have rehabilitation treatment on Wednesday, but starts again on Thursday. Mrs Jones has had a total of 3 treatment suspension days.

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

Total number of suspension occurrences

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition: Record the total number of rehabilitation treatment suspension occurances during this admission.

Justification: Achievement of a patient'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. Mrs Jones is admitted on Monday and commences treatment straight away. On Thursday her asthma flares up and she is unable to undertake her rehab program on Thursday and Friday. She starts again on Saturday. Next Wednesday her asthma flares up again and she does not have rehabilitation treatment on Wednesday, but starts again on Thursday. Mrs Jones has had 2 occurrences of treatment suspensions.

Will any services be received post discharge?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: This item identifies whether services were necessary post discharge. “Services” refers to paid or unpaid services required post discharge, that is: all services that have been discussed, agreed, planned and booked for the patient prior to discharge. Paid service(s) include both government funded and private health funded services. Unpaid service(s) include care provided by a relative, friend, or partner.

Justification: Service(s) received relates to degree of functional independence of the person, and as increased functional independence is a key outcome measure for rehabilitation, it is important to ascertain the person's level of functional independence before and after rehabilitation. Service(s) received before and after rehabilitation can be compared as a indication of any change in the person's functional independence after rehabilitation.

Guide for use: Only collect this data item if the patient’s final discharge destination was private residence (including unit in retirement village), otherwise leave blank. Record 1,”Yes", if service(s) required and 2,”No", if no service(s) are required post discharge.

Codeset values:

1	Yes
2	No

Services received post discharge

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

This item identifies whether services were necessary post discharge. “Services” refers to paid or unpaid services required post discharge, that is: all services that have been discussed, agreed, planned and booked for the patient prior to discharge

Justification:

The type of service(s) received before and after rehabilitation can be compared as an indication of patient's rehabilitation progress.

Guide for use:

Only collect this data item if the patient requires any paid or unpaid assistance post discharge. Record 1, "Yes" if they require assistance and 2, "No" if they do not require assistance (paid or unpaid). Unpaid assistance is when a service is provided by a relative, friend or partner. Discretionary services received by the patient, but not functionally necessary, should not be included (e.g. a house clearner because the patient doesn't like cleaning rather than functionally can't clean).

Domestic tasks include: household cleaning, vacuuming, ironing, shopping, managing finances and meal preparation.
Paid domestic assistance service(s) include both government funded and private health funded services.

Social support includes: daily wellbeing through telephone calls, medication reminders, counselling etc. Paid social support service(s) include both government funded and private health funded services.

Nursing care includes: nurse visiting a patient to administer wound care, medication, manage incontinence etc. Paid nursing care includes both government funded and private health funded services.

Allied health care includes: provision of physiotherapy, occupational therapy, speech and language therapy, recreational therapy, social work, psychology etc. Paid allied health care include both government funded and private health funded services.

Personal care includes: washing, dressing, grooming, eating, toileting etc. Paid personal care service(s) include both government funded and private health funded services.

Meals include: ready meals like meals on wheels or lite and easy meals etc. Paid meal service(s) include both government funded and private health funded meal services.

Goods and equipment include: specialised equipment e.g. shower chair, commode, hoist, wheelchair OR smaller aids e.g. plate guard for eating, adapted cutlery, long handled sponge for washing etc. Paid goods and equipment include both government funded and private health funded goods and equipment.

Transport services include: community transport for shopping or attending medical appointments, taxi vouchers, community bus and/ or use of patient transport assistance vehicle etc. Paid transport service(s) include both government funded and private health funded services.

Case management may be defined as a service that provides assessment, planning, facilitation and advocacy for options and services to meet a patients needs. Paid case management includes both government funded and private health funded case management services.

Data Items:

Service received post discharge - Domestic assistance
Service received post discharge - Social support
Service received post discharge - Nursing care
Service received post discharge - Allied health care
Service received post discharge - Personal care
Service received post discharge - Meals
Service received post discharge - Provision of goods & equipment
Service received post discharge - Transport services
Service received post discharge - Case management

Codeset values:

1	Yes
2	No

Will a discharge plan be available to patient prior to discharge?

Pathway: 1 ☐ 2 ☐ 3 ☑

Definition: A discharge plan is a formal document that summarises the episode of rehabilitation, and provides information about medications the patient was receiving on discharge, and follow-up care (such as doctor's appointments). This document may also be sent (or faxed) to the GP on discharge.

Justification: This item is required for collection and calculation of the version 4 ACHS Rehabilitation Medicine clinical indicators; ensures discharge plan is established prior to patient separation.

Guide for use: Answer 1, "Yes" if the patient is provided with a formal document that summarises the episode of rehabilitation, and provides information about medications the patient was receiving on discharge and follow-up care (such as doctors appointments). This document may also be sent (or faxed) to the GP on discharge, otherwise answer 2, "No".

Codeset values:

1	Yes
2	No

Date patient emerged from PTA

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the date the patient emerged from post traumatic amnesia (PTA).

Justification: Duration of PTA data is collected to establish whether there is a relationship between PTA duration and length of stay (LOS) and/or FIM change. By recording the date patient emerged from PTA, we can calculate the number of days the patient was in PTA, group the cohort into severity and analyse whether there is a relationship between PTA duration and LOS and/or FIM change. It is hypothesised that a longer time in PTA leads to increased LOS and decreased FIM change.

Guide for use: Collect for all traumatic brain injury episodes (AROC impairments 2.21, 2.22, 14.1 and 14.2). Record the date that the patient emerged from post traumatic amnesia (PTA). PTA is measured using a PTA scale and represents a stage of recovery during which a patient's orientation and memory for ongoing events remains poor.

There are different scales available and being used by different states. The most common scales include The Westmead PTA Scale, The Modified Oxford PTA Scale and the Julia Farr. A common question is: “When to cease testing?” Testing should cease at 6 months (183 days) and then class patient as “chronic amnesic” . Other circumstances to cease testing may include: patient becoming frustrated with testing, clinician getting the feeling that clinically the patient has emerged from PTA and neuropsychology assessment confirms this. What if patient emerged from PTA prior to being admitted to rehabilitation? Clinicians should try their utmost to get the date the patient emerged from PTA from referring hospital.

Duration of PTA

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: The number of days a patient with a TBI was in post traumatic amnesia (PTA).

Justification: Duration of PTA data is collected to establish whether there is a relationship between PTA duration and length of stay (LOS) and/or FIM change. By recording the number of days a patient is in PTA, we can calculate and group the cohort by severity of PTA and then analyse whether there is a relationship between PTA duration and LOS and/or FIM change. It is hypothesised that a longer duration of PTA leads to increased LOS and decreased FIM change.

Guide for use: Collect for all traumatic brain injury episodes (AROC impairments 2.21, 2.22, 14.1 and 14.2). Only collect if "Date emerged from PTA" is unknown. If "Date emerged from PTA" is known, leave blank.

PTA is measured using a PTA scale and represents a stage of recovery during which a patient's orientation and memory for ongoing events remains poor. There are different scales available and being used by different states. The most common scales include The Westmead PTA Scale, The Modified Oxford PTA Scale and the Julia Farr. A common question is: “When to cease testing?” Testing should cease at 6 months (183 days) and then class patient as “chronic amnesic” . Other circumstances to cease testing may include: patient becoming frustrated with testing, clinician getting the feeling that clinically the patient has emerged from PTA and neuropsychology assessment confirms this. What if patient emerged from PTA prior to being admitted to rehabilitation? Clinicians should try their utmost to get the date the patient emerged from PTA from referring hospital, or at a minimum the number of days the patient was in PTA.

Codeset values:

0	PTA not recorded
1	0 days (i.e. never in PTA)
2	1 day (i.e. couple of mins up to 24 hours)
3	2-7 days
4	8-28 days
5	29-90 days
6	91-182 days
7	183 days or more (chronic amnesic)
8	PTA unable to be recorded
9	In PTA at discharge

ASIA Score (AIS grade) at Episode Start

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the patient's American Spinal Injury Association Impairment Scale (AIS) grade at the start of their rehabilitation episode.

Justification: This item is required to enable analysis of change between AIS grade on admission and discharge from rehabilitation.

Guide for use: Collect for AROC impairment code 4 only. Leave blank for all other AROC impairment codes.

We acknowledge the National Injury Surveillance Unit (NISU) guidelines to complete the AIS grade 4 weeks post injury, however for the purposes of this data collection tool and the manner in which the data is to be utilised, please record the patient's AIS grade at the start of their inpatient rehabilitation episode.

Codeset values:

1	A
2	B
3	C
4	D
5	E

Level of Spinal Cord Injury at Episode Start

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the level of spinal cord injury (SCI) at the start of their rehabilitation episode of care.

Justification: This item is required to enable analysis of change between level of SCI at admission and discharge from rehabilitation.

Guide for use: Collect for AROC impairment code 4 only. Leave blank for all other AROC impairment codes.
If patient is cauda equina, record “cauda equina” in general comment field. If unable to establish level of injury, record “paraplegia” or “quadriplegia” in the general comments field.

Codeset values:

1	C1
2	C2
3	C3
4	C4
5	C5
6	C6
7	C7
8	C8
9	T1
10	T2
11	T3
12	T4
13	T5
14	T6
15	T7
16	T8
17	T9
18	T10
19	T11
20	T12
21	L1
22	L2
23	L3
24	L4
25	L5
26	S1
27	S2
28	S3
29	S4
30	S5

Level of Spinal Cord Injury at Episode End

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the level of spinal cord injury (SCI) within the week prior to discharge from rehabilitation.

Justification: This item is required to be able to group patients into cohorts to enable analysis of functional change and benchmarking.

Guide for use: Collect for AROC impairment code 4 only. Leave blank for all other AROC impairment codes.
If patient is cauda equina, record “cauda equina” in general comment field. If unable to establish level of injury, record “paraplegia” or “quadriplegia” in the general comments field.

Codeset values:

1	C1
2	C2
3	C3
4	C4
5	C5
6	C6
7	C7
8	C8
9	T1
10	T2
11	T3
12	T4
13	T5
14	T6
15	T7
16	T8
17	T9
18	T10
19	T11
20	T12
21	L1
22	L2
23	L3
24	L4
25	L5
26	S1
27	S2
28	S3
29	S4
30	S5

Ventilator Dependent at Episode End

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Ventilator dependent may be defined as the use of mechanical ventilation for at least six hours daily for at least 21 days. Record if patient is ventilator dependent at the time of discharge from rehabilitation.

Justification: Patients who are dependent on a ventilator require very high levels and hours of attendant care. These episodes of care need to be FLAGGED.

Guide for use: Collect for AROC impairment code 4 only. Leave blank for all other AROC impairment codes.
Record if patient is ventilator dependent at the time of discharge from rehabilitation.

Codeset values:

1	Yes
2	No

ASIA Score (AIS grade) at Episode End

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the patient's American Spinal Injury Association Impairment Scale (AIS) grade in the week prior to discharge from rehabilitation.

Justification: This item is required to be able to group patients into cohorts to enable analysis of functional change and benchmarking.

Guide for use: Collect for AROC impairment code 4 only. Leave blank for all other AROC impairment codes.

Codeset values:

1	A
2	B
3	C
4	D
5	E

Date Ready for Casting

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	Record the date the treating rehabilitation physician or team deems the stump is ready for casting.
Justification:	This item is required to establish time periods between critical points through the rehabilitation episode.
Guide for use:	Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes. If the date is known enter exact date. Use date format DD/MM/YYYY. If casting is planned but the date is not yet known enter 07/07/7777. If casting is not clinically appropriate enter 08/08/8888.

Phase of Amputee Care at Episode Start

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the phase of amputee care the patient is in at episode start (admission).

Justification: This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.
Use the code set definitions to assist with defining of amputee phase of care at admission. Record 1 phase only.
Within the codeset:
Pre-operative phase is the phase during which the clinical decision to perform amputation occurs, including assessment of urgency (following trauma or infection). A comprehensive interdisciplinary baseline assessment of the patient's status including medical assessment, functional status (including function of contralateral limb), pain control and psychological and cognitive assessment is completed. Patient's goals, social environment and support systems are all defined. A post-operative care plan should be determined by the surgeon and rehabilitation team to address medical, wound or surgical and rehabilitation requirements.

Delayed wound phase is the phase where problems occur with wound healing and additional interventions are considered as needed, including revision surgery, vascular and infection evaluation, aggressive local wound care and hyperbaric oxygen.

Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters inpatient rehabilitation program or is treated in ambulatory setting. Post-operative assessment to review patient's status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Provide physical and functional interventions based on current and potential function. Determine whether a prosthesis is appropriate to improve functional status and meet realistic patient goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. Prosthesis is prescribed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided.

Follow-up phase is the phase where follow-up appointment after discharge from rehabilitation is scheduled. Assessment of patient's goals, functional assessment, secondary complications, prosthetic assessment (repair, replacement, mechanical adjustment and new technology) and vocational and recreational needs are completed. Secondary amputation prevention is provided (where relevant). This also includes the provision of rehabilitation for patients who are not suitable for a prosthesis. Rehabilitation focus may include transfers, functional mobility, wheelchair mobility, ADL training.

Codeset values:

1	Pre-operative
2	Delayed wound
3	Pre-prosthetic
4	Prosthetic
5	Follow-up

Phase of amputee care during episode - Delayed wound?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record whether the amputee patient passed through the phase “delayed wound” during their rehabilitation episode. The phase “delayed wound” is the phase where problems with wound healing occur and additional interventions should be considered including: revision surgery, vascular and infection evaluation, aggressive local wound care and hyperbaric oxygen.

Justification: This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes. Record 1, “Yes” or 2,” No” if the patient passes through the phase “delayed wound” during their rehabilitation episode.

Codeset values:

1	Yes
2	No

Phase of amputee care during episode - Pre-prosthetic?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition:

Record whether the amputee patient passed through the phase “pre prosthetic” during their rehabilitation episode.
Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters inpatient rehabilitation program or is treated in ambulatory setting. Post-operative assessment to review patient’s status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Provide physical and functional interventions based on current and potential function. Determine whether a prosthesis is appropriate to improve functional status and meet realistic patient goals.

Justification:

This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use:

Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.
Record 1, “Yes” or 2,” No” if the patient passes through the phase “pre prosthetic” during their rehabilitation episode.

Codeset values:

1	Yes
2	No

Phase of amputee care during episode - Prosthetic?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record whether the amputee patient passed through the phase “prosthetic” during their rehabilitation episode. Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. Prosthesis is prescribed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided.

Justification: This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.
Record 1, “Yes” or 2,” No” if the patient passes through the phase “prosthetic” during their rehabilitation episode.

Codeset values:

1	Yes
2	No

Phase of amputee care at episode end

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record phase of amputee care just before discharge from rehabilitation.

Justification: This item is required to be able to define the different paths through rehabilitation for amputees and to ensure benchmarking between like cohorts.

Guide for use:

Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.
Use the code set definitions to assist with defining of amputee phase of care at episode end (discharge).
Record 1 phase only.
Within the codeset:
Pre-operative phase is the phase during which the clinical decision to perform amputation occurs, including assessment of urgency (following trauma or infection.) A comprehensive interdisciplinary baseline assessment of the patient's status including medical assessment, functional status (including function of contralateral limb), pain control and psychological and cognitive assessment is completed. Patient's goals, social environment and support systems are all defined. A post-operative care plan should be determined by the surgeon and rehabilitation team to address medical, wound or surgical and rehabilitation requirements.

Delayed wound phase is the phase where problems occur with wound healing and additional interventions are considered as needed, including revision surgery, vascular and infection evaluation, aggressive local wound care and hyperbaric oxygen.

Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters inpatient rehabilitation program or is treated in ambulatory setting. Post-operative assessment to review patient's status, including physical and functional assessment; completion of FIM baseline and other relevant assessments are completed. Rehabilitation goals are determined, rehabilitation treatment plan is established and updated and patient education is provided. Provide physical and functional interventions based on current and potential function. Determine whether a prosthesis is appropriate to improve functional status and meet realistic patient goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. Prosthesis is prescribed based on current or potential level of ambulation. Patient receives interim or permanent prosthetic fitting and training, and early rehabilitation management. Prosthetic gait training and patient education on functional use of prosthesis for transfers, balance and safety is provided.

Follow-up phase is the phase where follow-up appointment after discharge from rehabilitation is scheduled. Assessment of patient's goals, functional assessment, secondary complications, prosthetic assessment (repair, replacement, mechanical adjustment and new technology) and vocational and recreational needs are completed. Secondary amputation prevention is provided (where relevant). This also includes the provision of rehabilitation for patients who are not suitable for a prosthesis. Rehabilitation focus may include transfers, functional mobility, wheelchair mobility, ADL training.

Codeset values:

1	Pre-operative
2	Delayed wound
3	Pre-prosthetic
4	Prosthetic
5	Follow-up

Prosthetic device fitted?

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: A patient is deemed “prosthetic” if they already have a prosthetic device fitted, or will have one fitted in the future. A patient is deemed “non-prosthetic” if there is no intention to fit a limb.

Justification: This item is required to be able to define cohorts to ensure appropriate benchmarking.

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes. Record 1, “Yes”, if they already have a prosthetic device fitted, or will have one fitted in the future. Record 2, “No”, if there is no intention to fit a limb. Only record this data item for lower limb amputees.

Codeset values:

1	Yes
2	No

Date of first prosthetic fitting

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the date of the first interim prosthetic fitting.

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

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.
Only complete this item if patient is prosthetic, that is: you answered 1,"Yes" to the data item, "does the patient have a prosthetic device fillted, OR will have one fitted in the future?".

If date is known enter exact date. Use the date format DD/MM/YYYY.
If a prosthetic fitting is planned but the date not yet known enter 07/07/7777.
If the patient has a prosthetic device fitted but the date of fitting is not known enter 09/09/9999.

Reason for delay in first prosthetic fitting

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Record the reason for the delay in first interim prosthetic fitting.

Justification: This item is required to be able to identify the reasons causing delays, so that they can be addressed.

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.
Only complete this item if patient is “prosthetic”, that is: you answered ”Yes” to the data item, "prosthetic?" If there was no delay, record 0, “No delay”. If the reason for delay is not listed, record 6, “All other issues” and provide details in the general comment section.

Codeset values:

0	No Delay
1	Issues around wound healing
2	Other issues around the stump
3	Other health issues of the patient
4	Issues around availability of componentry
5	Issues around availability of the service
6	All other issues (to be specified in the AROC comment section)

Discharge timed up and go test

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the time in completed seconds and complete assessment just before patient is discharged.

Justification: This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.

Guide for use: Collect for AROC impairment code 5 only.Leave blank for all other AROC impairment codes.

Record time in COMPLETED seconds e.g:
If patient takes 9.3 seconds to complete TUG, record 9 seconds.
If patient takes 9.7 seconds to complete TUG, record 9 seconds.
If patient takes 1 minute 18 seconds, record 78 seconds.

If the patient is unable to complete the test or the test is non applicable for this episode of care, code 9999.

Discharge 6 minute walk test

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition:	Record distance in metres. Complete the 6 minute walk test just before patient is discharged.
Justification:	This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.
Guide for use:	Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes. If the patient is unable to complete the test or the test is non applicable for this episode of care, code 999.9.

Discharge 10 metre walk +/- aid test

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Record the time in completed seconds and complete assessment just before patient is discharged.

Justification: This is a functional outcome measure. It is required to enable groupings of patients with similar levels of amputation and analysis of their outcomes. There are also population averages, which can serve as benchmarks.

Guide for use: Collect for AROC impairment code 5 only. Leave blank for all other AROC impairment codes.

Record time in COMPLETED seconds e.g:
If patient takes 20.2 seconds to complete the 10 metre walk +/- aid test , record 20 seconds.
If patient takes 20.8 seconds to complete 10 metre walk +/- aid test, record 20 seconds.
If patient takes 1 minute 18 seconds, record 78 seconds.

If the patient is unable to complete the test or the test is non applicable for this episode of care, code 9999.

Rockwood Frailty Score (pre-morbid)

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Frailty may be defined as a condition, seen particularly in older patients, characterized by low functional reserve, easy tiring, decreased libido, mood disturbance, accelerated osteoporosis, decreased muscle strength, and high susceptibility to disease. Record the patient's level of frailty just before they had their injury (impairment) or exacerbation of impairment resulting in this rehabilitation episode of care.

Justification: This item is required to be able to define cohorts to ensure appropriate benchmarking.

Guide for use: Collect for AROC impairment code 5 and 16 only.Leave blank for other AROC impairment codes.
Use the Rockwood Clinical Frailty Scale to record the patient's level of frailty prior to their injury or exacerbation of impairment.

Codeset values:

1	Very fit
2	Well
3	Well, with treated comorbid disease
4	Apparently vulnerable
5	Mildly Frail
6	Moderately Frail
7	Severely Frail
8	Terminally ill
9	Unknown or N/A

Was patient able to participate in therapy from day 1?

Pathway: 1 ☐ 2 ☑ 3 ☑

Definition: Was the patient able to take part in their rehabilitation therapy program from their episode start date?

Justification: This item is required to enable more appropriate groupings of de-conditioned patients for benchmarking and outcome measurement.

Guide for use: Collect for AROC impairment code 16 only. Leave blank for other AROC impairment codes.

Codeset values:

1	Yes
2	No

Has patient fallen in the last 12 months?

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: A fall may be defined as "an unexpected event where a person falls to the ground from an upper level or the same level". Record whether the patient fallen in the last 12 months.

Justification: This item is required to enable more appropriate groupings of de-conditioned patients for benchmarking and outcome measurement.

Guide for use: Collect for AROC impairment code 16 only. Leave blank for other AROC impairment codes.
Interview the patient and/or family to gather this information.

Codeset values:

1	Yes
2	No

Has the patient lost > 10% of their body weight in the last 12 months?

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Has the patient lost more than 10% of their body weight in the last 12 months?

Justification: This item is required to enable more appropriate groupings of de-conditioned patients for benchmarking and outcome measurement.

Guide for use: Collect for AROC impairment code 16 only. Leave blank for other AROC impairment codes.
Interview the patient and/or family to gather this information.

Codeset values:

1	Yes
2	No

General Comments

Pathway: 1 ☑ 2 ☑ 3 ☑

Definition: Comment relevant to this episode of care.

Justification: N/A

Guide for use: N/A