AUSTRALASIAN REHABILITATION OUTCOMES CENTRE

INREACH DATA DICTIONARY VI

FOR CLINICIANS - NEW ZEALAND VERSION

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

UNIVERSITY OF WOLLONGONG AUSTRALIA

aroc.org.au

Contacting AROC:
Email: aroc@uow.edu.au
Phone: (02) 4221 4411

Inreach Data Dictionary for Clinicians

BACKGROUND

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

INREACH DATA DICTIONARY VERSION

Version	Date	Nature of change
1	July 2023	• First version of official Inreach data dictionary. Prior to the inception of this dictionary all inreach information was captured in the Inpatient Data Dictionary

Contacting AROC:

Email: aroc@uow.edu.au **Phone:** (02) 4221 4411 **Website:** aroc.org.au

AROC Inreach Data Dictionary for Clinicians (NZ) V1

Path

Pathway: **2**

Definition: In-reach (Pathway 2):
-The patient is under the care of an acute physician who holds the medical governance.
-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.

Justification: Enables assignment of episodes of care to the correct pathway for analysis.

Guide for use: Select the inreach 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: **2**

Definition:	A code which represents the facility.
Justification:	Enables episodes of care to be assigned to the correct facility for analysis.
Guide for use:	This would usually be the code issued by the Department of Health.

Ward ID/Team ID

Pathway: **2**

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

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

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

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

Ward Name/Team Name

Pathway: **2**

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

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

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

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

Patient Identifier

Pathway: **2**

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

Letters of Name

Pathway: **2**

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: **2**

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: **2**

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: **2**

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

Justification: Collected to allow analysis of outcomes by sex.

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

Codeset values:

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

Indigenous Status (NZ)

Pathway: **2**

Definition: In NZ, indigenous status is a measure of whether a patient identifies as being of Maori or Non-Maori origin.

Justification: New Zealand's Maori 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 Maori or non-Maori in New Zealand.

Guide for use: N/A

Codeset values:

1	Maori
4	Non-Maori
9	Not stated or inadequately defined

Ethnicity

Pathway: **2**

Definition: Ethnicity is defined as a social group whose members have one or more of the following four characteristics: they share a sense of common origins, claim a common and distinctive history and destiny, possess one or more dimensions of collective cultural individuality and/or feel a sense of unique collective solidarity.

Justification: In NZ, there is a focus on understanding health outcomes for different ethnic groups.

Guide for use: A person may identify with some or all four of the above characteristics in one context and identify with a different mix of characteristics in another, resulting in a different choice of ethnic affiliation. Given this possibility, it would be extremely difficult for anybody other than the person concerned to choose which ethnic group they identify with in a particular circumstance. Therefore the person concerned should identify their ethnic affiliation wherever feasible. If not feasible, ask family or friend.

Codeset values:

10	European not further defined
11	New Zealand European/Pakeha
12	Other European
21	Maori
30	Pacific Peoples not further defined
31	Samoan
32	Cook Island Maori
33	Tongan
34	Niuean
35	Tokelauan
36	Fijian
37	Other Pacific Peoples
40	Asian not further defined
41	Southeast Asian
42	Chinese
43	Indian
44	Other Asian
51	Middle Eastern
52	Latin American/ Hispanic
53	African (or cultural group of African origin)
61	Other Ethnicity
94	Patient doesn't know
95	Refused to Answer
97	Response Unidentifiable
99	Not stated

Postcode

Pathway: **2**

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 (NZ)

Pathway: **2**

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	NZ Ministry of Health (public patient)
2	Private health insurance
3	Self-funded
4	Workers compensation
5	Motor vehicle third party personal claim
6	Other compensation (eg public liability, common law, medical negligence)
10	Other hospital or public authority (contracted care)
11	Reciprocal health care agreement (other countries)
12	NZ Disability
13	Accident Compensation Corporation
98	Other
99	Not known

Health Fund/other payer

Pathway: 2

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

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

Guide for use: 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)

Referral Date

Pathway: **2**

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 the date a referral is received and the 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 inaccurate to include these extra days in the analysis. Under other circumstances, date referral received and date referral made will be the same.

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

For example:
An inpatient in the Intensive Care Unit (ICU) was thought clinically ready for rehabilitation on 01/02/2012. A clinician in ICU calls the in-reach rehabilitation team and makes a verbal referral the same day. Record 01/02/2012, the date the referral was received by the rehabilitation team.

Assessment Date

Pathway: **2**

Definition:	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 throughout the rehabilitation episode.
Guide for use:	N/A

Date clinically ready for rehabilitation care

Pathway: **2**

Definition:	A patient is “clinically ready for rehabilitation care” 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 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 which may or may not be the date rehabilitation actually started.

Was there a delay in episode start?

Pathway: **2**

Definition: This item identifies whether there was a delay between the patient being assessed as clinically ready for rehabilitation and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the rehabilitation program commencing.

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

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

Codeset values:

1	Yes
2	No

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

Pathway: **2**

Definition: This item collects information about patient related medical issues that have caused a delay between the patient being assessed as clinically ready for rehabilitation and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the rehabilitation program commencing.

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

Guide for use: For example:
The patient was assessed as clinically ready for rehabilitation, but can only be admitted once 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: **2**

Definition:

This item collects information about service issues that have caused a delay between the patient being assessed as clinically ready for rehabilitation and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the rehabilitation program commencing.

Service issues are those that are governed by the rehabilitation service or the hospital service that impact the rehabilitation episode.

Justification:

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

Guide for use:

For example:
There is no capacity available in the inreach team so the patient is on the waiting list until there is capacity 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 the episode start.

Codeset values:

1	Yes
2	No

Reason for delay in episode start - External support issues

Pathway: **2**

Definition: This item collects information about external support issues that have caused a delay between the patient being assessed as clinically ready for rehabilitation and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the rehabilitation program commencing.
External support issues are those that are not governed by the hospital system.

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

Guide for use: 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: **2**

Definition:

This item collects information about equipment issues that have caused a delay between the patient being assessed as clinically ready for rehabilitation and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the rehabilitation program commencing.

Justification:

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

Guide for use:

For example:
Specialist equipment, such as bariatric equipment, is not available and needs to be hired prior to rehabiliation commencing.

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: **2**

Definition: This item collects information about patient behavioural issues that have caused a delay between the patient being assessed as clinically ready for rehabilitation and the rehabilitation program commencing. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the rehabilitation program commencing.

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

Guide for use: 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: **2**

Definition:	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 dependent on geography or location of the patient. The begin date for an inreach rehabilitation episode of care, is the date that the inreach team commenced the rehabilitation program/ provision of care.
Justification:	This item is required to establish time periods between critical points throughout the rehabilitation episode.
Guide for use:	Record the date the inreach team commenced the patient's rehabilitation program.

Type of Accommodation prior to this impairment (NZ)

Pathway: **2**

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	Rest home level care
3	Hospital level care (requires 24hr nursing)
4	Community group home
5	Boarding house
6	Transitional living unit
8	Other

Carer status prior to this impairment

Pathway: **2**

Definition:

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 includes care provided by a relative, friend, and/or partner of the patient.

Justification:

Carer status is a key outcome measure for rehabilitation. Carer status before and after rehabilitation can be compared as an 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.

A patient may receive care from both a carer who lives in and a carer not living in. In this case, code the carer who provides the higher proportion of care.

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: **2**

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, and/or partner of the patient.

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 an indication of 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.

Discretionary services received by the patient, but that are 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.

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: **2**

Definition:

This item collects information about whether the patient received paid or unpaid services in the month prior to their impairment. Paid service(s) include both government funded and private health funded services. Unpaid service(s) include care provided by a relative, friend, and/or partner of the patient.

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).

Discretionary services received by the patient, but that are 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 such as a shower chair, commode, hoist, wheelchair or smaller aids such as a 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 patient's needs. Paid case management includes both government funded and private health funded case management services

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: **2**

Definition: This item records the patient's employment status before their impairment or exacerbation of impairment.

Justification: Employment is an important outcome that can be measured throughout 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 their impairment or exacerbation of impairment. Within the codeset:
Employed 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, parents 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 returning 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

Date multi-disciplinary team rehabilitation plan established

Pathway: **2**

Definition:	A multidisciplinary team rehabilitation plan comprises a series of documented and agreed initiatives/treatment (specifying program goals and time frames), which has been established through multidisciplinary consultation and consultation with the patient.
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 ACHS Rehabilitation Medicine clinical indicators which reflects timely establishment of a multidisciplinary team rehabilitation plan.
Guide for use:	Record the date the multidisciplinary team rehabilitation plan is formally documented in the 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 patient's 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 relevant acute episode

Pathway: **2**

Definition:	The date of the acute admission relevant to the current episode of inreach rehabilitation.
Justification:	This item is collected to enable calculation of the time between acute admission and inreach rehabilitation start dates, and analysis against outcomes achieved.
Guide for use:	N/A

Mode of Episode Start - Inreach

Pathway: **2**

Definition: This item records the referral source of the patient for the inpatient rehabilitation episode.

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

Guide for use: If using 'Other', please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

Codeset values:

1	Inreach to acute ward
2	Inreach to mental health unit
3	Inreach to paediatric ward
4	Other

AROC Impairment Code

Pathway: **2**

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 provide assistance in correctly classifying rehabilitation episodes according to impairment groups.

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

The AROC Impairment Coding Guidelines are available on the AROC website (www.aroc.org.au) under "Tools and Resources/AROC V4 dataset 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
18.1	COVID-19 with pulmonary issues
18.2	COVID-19 with deconditioning
18.9	COVID-19 all other

Date episode start FIM assessed

Pathway: **2**

Definition:	The date that the patient’s admission Functional Independence Measure (FIM) scores were completed.
Justification:	This item is required for collection and calculation of the 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 the patient's admission to inreach rehabilitation team. 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.

Admission FIM Scores

Pathway: **2**

Definition: 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 FIM 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. The FIM is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM 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. FIM assessment should always be undertaken by credentialed FIM assessors.

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: **2**

Definition: 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, this item identifies if their rehabilitation has enabled them to achieve a level of function that allows them to return to work and at what level or if they have been unable to return to work.

Collection of this data will enable analysis of employment outcome achievement. For example, a patient 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

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: **2**

Definition:	The date the patient's discharge Functional Independence Measure (FIM) scores were completed.
Justification:	This item is required for collection and calculation of the ACHS Rehabilitation Medicine clinical indicators. It reflects timely assessment of function prior to discharge.
Guide for use:	Discharge FIM scoring needs to be completed before the patient is discharged from the rehabilitation program, ideally as close as possible before 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.

Discharge FIM scores

Pathway: **2**

Definition: 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 FIM 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. The FIM is a basic indicator of severity of disability. The functional ability of a patient changes during rehabilitation and the FIM 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.
FIM assessment should always be undertaken by credentialed FIM assessors.

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: **2**

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. •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.
Justification:	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. The date a patient is deemed community ready is not always the same as the actual discharge date

Was there a delay in discharge?

Pathway: **2**

Definition: This item identifies whether there was a delay between the patient being assessed as clinically ready for discharge from inpatient rehabilitation and the date of discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

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

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

Codeset values:

1	Yes
2	No

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

Pathway: **2**

Definition: This item collects information about patient related medical issues that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

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

Guide for use: Only record a delay in the discharge from the inreach rehabilitation team. If the patient is discharged from the inreach rehabilitation team at the finish of their rehab program but remains in hospital under the care of the acute team do not record this as a delay.

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: **2**

Definition:

This item collects information about service issues that have caused a delay between the patient being assessed as clinically ready for discharge from inpatient rehabilitation and the date of discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

Service issues are those that are governed by the rehabilitation service or the hospital service that impact the rehabilitation episode.

Justification:

This item enables identification of the rehabilitation episodes whose rehabilitation end was delayed by service issues.

Guide for use:

Examples include:
Transport not available to transfer patient to discharge destination.

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

Patient requires ambulatory rehabilitation services, however there is a waiting list. The inpatient team feel that the patient cannot 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: **2**

Definition:

This item collects information about external support issues that have caused a delay between the patient being assessed as clinically ready for discharge from inpatient rehabilitation and the date of discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

External support issues are those that are not governed by the hospital system.

Justification:

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

Guide for use:

For example:
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.

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

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, however the family or friend will be out of town at time of discharge.

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

Patient has no available accommodation to be discharged to or 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: **2**

Definition: This item collects information about equipment issues that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program

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

Guide for use: For example:
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: **2**

Definition: This item collects information about patient behavioural issues that have caused a delay in discharge. A delay is only recorded when there is more than 24 hours between being assessed as clinically ready and the date of discharge from the rehabilitation program.

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

Guide for use: For example:
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: **2**

Definition: A comorbidity is defined as any other significant existing illness/impairment, not part of the principal impairment, 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 has stable controlled atrial fibrillation. DO NOT code as a comorbidity.

The patient has congestive heart failure which limits therapy sessions to only 10-15mins.

Patient has residual hemiplegia and cognitive impairment from a previous stroke that affected their participation in their current rehabilitation program.

Patient has a previous stroke but their residual impairments do not affect their rehabilitation program. DO NOT code as a comorbidity.

Do not leave blank.

Codeset values:

1	Yes
2	No

Comorbidity Items

Pathway: **2**

Definition: Comorbidities interfering with the rehabilitation program (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 outcomes and length of stay.

Guide for use: If there is an existing comorbidity interfering with this episode, then record up to a maximum of four comorbidities from the codeset.

If using 'Other', please use the General comments section to detail the comorbidity.

If you find a trend in your patient group that is not covered by the codeset options, please contact AROC.

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
25	Acute COVID (1-4 weeks)
26	Post COVID (5-12 weeks)
27	Long COVID (13+ weeks)
99	Other

Were there any complications interfering with this episode?

Pathway: **2**

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 developed a pressure ulcer which prevented them from engaging at the anticipated intensity in their planned rehabilitation program.

A patient developed a UTI, became confused and was unable to engage at the anticipated intensity in their planned rehabilitation program.

A patient has a fall during their rehabilitation episode and suffers bruising and a lack of confidence that resulted in the patient missing some days of therapy.

A patient has an electrolyte imbalance which is managed by IV fluids. The fluids are delivered around the patient’s rehabilitation program allowing them to continue their normal program. DO NOT code as a complication.

A patient develops urinary incontinence during their rehabilitation episode. This is well managed with incontinence pads which allows the patient to continue their rehabilitation program with minimal interruptions. DO NOT code as a complication.

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: **2**

Definition: Complications arising during the rehabilitation episode and interfering with the planned rehabilitation program (up to four can be selected).

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

Guide for use: If there is an existing complication interfering with this episode indicated then record up to a maximum of four complications from the codeset.

If using 'Other', please use the General comments section to detail the comorbidity.

If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

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
13	Acute COVID 1-28 days since COVID diagnosis (Weeks 1-4)
99	Other

Episode end date

Pathway: **2**

Definition:	The date that the patient completed their inreach rehabilitation episode. This date defines the end of the inreach rehabilitation episode and is the date at which the length of stay (LOS) concludes. The inreach rehabilitation episode ends when the patient is discharged from the inreach rehabilitation team.
Justification:	This item is required to establish time periods between critical points throughout the rehabilitation episode.
Guide for use:	Record the date that the patient either completed their rehabilitation episode and were discharged, were care type changed, or the one-off rehabilitation consultation was completed.

Mode of episode end (Inreach)

Pathway: **2**

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

Justification: This data item defines how the patient ended their rehabilitation journey. Different exit points are indicative of a patient's progress in rehabilitation and will be used to group patients for analysis of outcomes.

Guide for use: Where patients are discharged directly into the community from the inreach rehabilitation program use mode of episode end of final or interim destination as applicable.

If a patient has completed their rehabilitation program, (i.e. is either the achieved their rehabilitation goals or rehabilitation was ceased prior to goals being achieved as the goals were no longer deemed relevant or achievable.), but remains in hospital use mode of episode end Rehab interventions finished, remains in hospital.

If rehabilitation program is no longer deemed suitable due to a change in the medical stability of the patient (e.g. an acute deterioration) use mode of episode end Change in medical stability, no longer suitable for rehab; remains in hospital.

Please carefully consider the use of 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 desination
2	Discharged to interim destination
3	Death
4	Rehab interventions finished; remains in hospital
5	Change in medical stability, no longer suitable for rehab; remains in hospital
6	Transferred to inpatient rehabilitation ward same organisation/district/health service
7	Transferred to inpatient rehabilitation ward different organisation/district/health service
8	Discharged at own risk
9	Other and unspecified

Interim destination (NZ)

Pathway: **2**

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	Rest home level care
3	Hospital level care (requires 24hrs nursing)
4	Community group home
5	Boarding house
6	Transitional living unit
7	Hospital
8	Other
9	Unknown

Final destination (NZ)

Pathway: **2**

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	Rest home level care
3	Hospital level care (requires 24hrs nursing)
4	Community group home
5	Boarding house
6	Transitional living unit
8	Other
9	Unknown

Carer status post discharge

Pathway: **2**

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

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

A patient may receive care from both a carer who lives in and a carer who does not live in. In this case, code the carer who provides the higher proportion of care.

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: **2**

Definition:	The total number of days that therapy was 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 for a one-off assessment (consult liaison), for example: where 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: **2**

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 patient outcomes.
Guide for use:	In the inpatient setting, this item is only collected for inpatients who are seen for a one off assessment (consult liaison), for example: where 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: 2

Definition: 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.
If using 'Other', please use the General comments section to provide additional information.
If you find a trend in your patient group that is not covered by the codeset options please contact AROC.

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 suspension days

Pathway: **2**

Definition:

The sum of the number of days rehabilitation treatment was suspended for a medical reason during an episode of rehabilitation. 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. The suspension period must be a minimum of 1 day (24 hours).

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:

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

A medical condition that prevents the patient participating in their rehabilitation program. 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.

The requirement for a medical procedure (eg. Gastroscopy, renal dialysis, chemotherapy) 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.

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

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).

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.

Total number of suspension occurrences

Pathway: **2**

Definition: The total number of rehabilitation treatment suspension occurrences 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 the number of periods of rehabilitation treatment suspensions that occurred during the episode. If there were none, enter 0.

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 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: **2**

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 the 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 an 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 is 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.
Discretionary services received by the patient, but that are not functionally necessary, should not be included e.g. a house cleaner because the patient doesn’t like cleaning, rather than functionally unable to clean.

Codeset values:

1	Yes
2	No

Services received post discharge

Pathway: **2**

Definition:

This item collects information about 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, and/or partner of the patient.

Justification:

The type of service(s) received before and after rehabilitation can be compared as an indication of the 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).
Discretionary services received by the patient, but that are 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 includes 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 patient’s needs. Paid case management includes both government funded and private health funded case management services.

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: **2**

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 to the GP on discharge.

Justification: A discharge plan is best practice to ensure a patient's ongoing rehabilitation and medical needs are communicated.

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 doctor's appointments). This document may also be sent to the GP on discharge, otherwise answer 2, "No".

Codeset values:

1	Yes
2	No

Date patient emerged from PTA

Pathway: **2**

Definition: 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 the patient emerged from PTA, the number of days the patient was in PTA can be calculated, the cohort grouped into severity and analysed as to 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). If the date is unknown, leave blank and collect data item ‘Duration of PTA’ instead.

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 the 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.
If the 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 the referring hospital.

Duration of PTA

Pathway: **2**

Definition: The number of days a patient with a traumatic brain injury (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 date the patient emerged from PTA, the number of days the patient was in PTA can be calculated, the cohort grouped into severity and analysed as to 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 those traumatic brain injury episodes (AROC impairments 2.21, 2.22, 14.1 and 14.2) where "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 the 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.
If the 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 the 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: **2**

Definition: 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 all spinal cord dysfunction episodes (AROC impairment codes 4.111-4.23, 14.1 and 14.3). Leave blank for all other AROC impairment codes.

We acknowledge the National Injury Surveillance Unit (NISU) guidelines to complete the AIS grade is at 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: **2**

Definition: 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 all spinal cord dysfunction episodes (AROC impairment codes 4.111-4.23, 14.1 and 14.3). Leave blank for all other AROC impairment codes.

If patient is cauda equina, record “cauda equina” in General comments 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: **2**

Definition:
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 all spinal cord dysfunction episodes (AROC impairment codes 4.111-4.23, 14.1 and 14.3).
Leave blank for all other AROC impairment codes.
If patient is cauda equina, record “cauda equina” in General comments 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: **2**

Definition: Ventilator dependent may be defined as the use of mechanical ventilation for at least six hours daily for at least 21 days.

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 all spinal cord dysfunction episodes (AROC impairment codes 4.111-4.23, 14.1 and 14.3). Leave blank for all other AROC impairment codes. Record if the 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: **2**

Definition:	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 all spinal cord dysfunction episodes (AROC impairment codes 4.111-4.23, 14.1 and 14.3). 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: **2**

Definition:	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 (amputation of limb) 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: **2**

Definition: 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 (amputation of limb) 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 an inpatient rehabilitation program or is treated in an 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. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. A prosthesis is prescribed based on current or potential level of ambulation. Patients receive 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 appointments after discharge from rehabilitation are 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: **2**

Definition: 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 enable analysis between like cohorts.

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only. Leave blank for all other AROC impairment codes. Record 1, “Yes” or 2,” No” to indicate 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: **2**

Definition: Pre-prosthetic phase is the phase where a patient is discharged from acute care and enters an inpatient rehabilitation program or is treated in an 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. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

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

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only. Leave blank for all other AROC impairment codes. Record 1, "Yes" or 2," No" to indicate 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: **2**

Definition: Prosthetic phase is the phase where functional goals of prosthetic fitting are determined.
A prosthesis is prescribed based on current or potential level of ambulation. Patients receive 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 enable analysis between like cohorts.

Guide for use: Collect for AROC impairment code 5 (amputation of limb) only. Leave blank for all other AROC impairment codes.
Record 1, “Yes” or 2,” No” to indicate 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: **2**

Definition: The 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 (amputation of limb) 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 an inpatient rehabilitation program or is treated in an 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. Physical and functional interventions are provided and decisions are made on the appropriateness of a prosthesis to improve a patient's functioning and meet their rehabilitation goals.

Prosthetic phase is the phase where functional goals of prosthetic fitting are determined. A prosthesis is prescribed based on current or potential level of ambulation. Patients receive 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 appointments after discharge from rehabilitation are 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: **2**

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 (amputation of limb) 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: **2**

Definition: 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 (amputation of limb) 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 fitted, 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: **2**

Definition: 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 (amputation of limb) 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 comments 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: **2**

Definition:	The time in completed seconds to complete the Timed Up and Go (TUG) test as assessed just before the 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 (amputation of limb) 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 not applicable for this episode of care, code 9999.

Discharge 6 minute walk test

Pathway: **2**

Definition:	The distance in metres completed during the 6 minute walk test, just before the 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 (amputation of limb) only. Leave blank for all other AROC impairment codes. If the patient is unable to complete the test or the test is not applicable for this episode of care, code 9999.

Discharge 10 metre walk +/- aid test

Pathway: **2**

Definition:	The time in completed seconds for walking 10 metres; as assessed just before the 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 (amputation of limb) 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 not applicable for this episode of care, code 9999.

Rockwood Frailty Score (pre-morbid)

Pathway: **2**

Definition:

Frailty may be defined as a condition, seen particularly in older patients, characterised by low functional reserve, easy tiring, decreased libido, mood disturbance, accelerated osteoporosis, decreased muscle strength, and high susceptibility to disease.

Justification:

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

Guide for use:

Collect for AROC impairment code 5 (amputation of limb) and 16 (reconditioning) only. Leave blank for all 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: **2**

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 deconditioned patients for benchmarking and outcome measurement.

Guide for use: Collect for AROC impairment code 16 (reconditioning) only. Leave blank for all other AROC impairment codes.

Codeset values:

1	Yes
2	No

Has patient fallen in the last 12 months?

Pathway: **2**

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". Only include falls within the last 12 months.

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

Guide for use: Collect for AROC impairment code 16 (reconditioning) only. Leave blank for all other AROC impairment codes. Interview the patient and/or family/carer 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: **2**

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 deconditioned patients for benchmarking and outcome measurement.

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

Codeset values:

1	Yes
2	No

General Comments

Pathway: **2**

Definition: Comment relevant to this episode of care.

Justification: This item allows additional information to be recorded.

Guide for use: Record any relevant comments about this episode of care, such as:

*any further details for any 'other' code used
*any further details useful to the facility

DO NOT RECORD PATIENT NAMES HERE