Rehabilitation Data Set

Data dictionary

Data elements

Demographics

Person Identifier

Definition:	The patient identifier (UR number) is a unique record number assigned to a person for the purpose of uniquely identifying them within a healthcare facility.
Format:	Alphanumeric; code X[X(19)] Character length – 1-20
Codeset values:	A valid identifier assigned using the Assignment of unique identifier standard
Source data standard:	Queensland Health Admitted Patient Care Data Set

Age

Definition:	A patient's age is their age in years at the time of their admission to rehabilitation. It is calculated as the episode begin date minus the patient's date of birth.
Format:	Numeral
Codeset values:	Any number above 1 in years.
Source data standard:	Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts-Australian Version

Indigenous Status

Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin
Format:	Numeric code
Codeset values:	1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Neither Aboriginal nor Torres Strait Islander origin 8 Not stated/unknown - follow-up required 9 Not stated/unknown - no follow-up required
Source data standard:	*Applicable data sources*: Queensland Data Standard Person and Provider Identification Data Set-Definitions (health.qld.gov.au) Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts-Australian Version (codes 8 and 9 = Not stated or inadequately defined)

Sex

Definition:	Sex refers to a person's biological characteristics. A person's sex is usually described as being either male or female. A person may have both male and female characteristics, or neither male nor female characteristics, or other sexual characteristics.
Format:	Numeric code
Codeset values:	1 Male 2 Female 3 Other 9 Not stated/ Inadequately described
Source data standard:	Australian Institute of Health and Welfare Person-sex METeOR Identifier: 635126 Australian Bureau of Statistics 2016. Standard for Sex and Gender Variables (Cat. no. 1200.0.55.012). Attorney-General's Department 2015. Australian Government Guidelines on the Recognition of Sex and Gender. Queensland source standard: Queensland Hospital Admitted Patient Data Collection

V1.0 Effective: July 2021 Review: January 2022

Metro North Health

Queensland Government

Language

Definition:	Preferred language of the person receiving rehabilitation services (including sign language)
Format:	Coded text
Codeset values:	Any value from Appendix G - Language Codes of the Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0
Source data standard:	Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0

Need for an interpreter

Definition:	Whether an interpreter service is required by or for a person (including sign language)
Format:	Numeric code
Codeset values:	1 Interpreter needed 2 Interpreter not needed 9 Unknown
Source data standard	Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0 pp. 109 – 110. 7.38 Interpreter required (public hospitals)

Premorbid health and psychosocial status

Medical/health history

Definition:	The previous medical conditions experienced by the person.
Format:	Coded text
Codeset values:	Any valid code from SNOMED CT-AU, mapped according to the following categories for AROC reporting purposes. Cardiac disease Respiratory disease Drug and alcohol abuse Dementia Delirium, pre-existing Mental health problem Renal failure with dialysis Renal failure NO dialysis Epilepsy Parkinson's disease Stroke Spinal cord injury/disease Brain injury Multiple sclerosis Hearing impairment Diabetes mellitus Morbid obesity Inflammatory arthritis Osteoarthritis Osteoporosis Chronic pain Cancer Pressure ulcer, pre-existing Visual impairment Other
Source data standard:	ieMR problems list with categories accessed via the Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts-Australian Version

Young AM, et al. BMJ Open 2022; 12:e058725. doi: 10.1136/bmjopen-2021-058725

Sensory impairments

Definition:	Details about a person's sensory impairments which existed prior to the current episode of care.
Format:	Coded text
Codeset values:	Blind - L eye Blind - R eye Hearing deficit - Left ear Hearing deficit - Right ear Nonverbal Sensation - touch deficit Speech deficit Uncorrected visual impairment Other:
Source data standard:	Collection source - ieMR

Drug and alcohol history

Definition:	An indicator of a person's tobacco/ alcohol/ substance use history
Format:	Coded text
Codeset values:	Use: Yes No Not indicated Details: Current Past Not indicated Substance type (illicit substances only) Amphetamines Cocaine Ecstasy Hallucinogens/LSD Heroin Inhalants/glue/solvents Marijuana Methamphetamines Prescription Medications Other Not indicated
Source data standard:	Collection source - ieMR

Psychosocial history – employment status

Definition:	The person's employment status prior to this impairment
Format:	Numeric code
Codeset values:	1. Employed 2. Unemployed 3. Student 4. Not in labour force 5. Retired for age 6. Retired for disability
Source data standard:	Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts-Australian Version

Young AM, *et al. BMJ Open* 2022; 12:e058725. doi: 10.1136/bmjopen-2021-058725

Psychosocial history – level of education

Definition:	The highest level of education obtained by the person
Format:	Numeric code
Codeset values:	1. None 2. Highschool 3. Some College 4. University degree 5. Post graduate degree
Source data standard:	Collection source - ieMR

Psychosocial history – preadmission living situation

Definition:	The living situation of the person prior to this episode of care.
Format:	Numeric code
Codeset values:	1. Private residence 2. Residential low level care (hostel) 3. Residential, high level care (nursing home) 4. Community group home 5. Boarding house 6. Transitional living unit. 7. Other
Source data standard:	Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts- Australian Version

Psychosocial history - trauma

Definition:	History related to injuries, abuse or neglect in the household and the type of abuse.
Format:	Coded text
Codeset values:	Yes No Type: Free text – character limited field
Source data standard:	Collection source - ieMR

Mood

Definition:	An indicator of mood at the commencement of the rehabilitation episode.
Format:	Numeral between 0 and 12
Codeset values:	Total score (0-12) Anxiety sub-scale (0-6, generated from Q1 and Q2) Depression sub-scale (0-6, generated from Q3 and Q4)
Source data standard:	Patient Health Questionnaire-4 (PHQ-4) (proposed measure)

Carer supports

Definition:	The level of carer support received by the patient prior to their current inpatient admission. Include both paid and unpaid support. Paid carer support includes both government funded and private health funded carers. Unpaid carer support include care provided by a relative, friend, partner etc.
Format:	Numeric code
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.
Source data standard:	Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts- Australian Version

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Community supports

Definition:	Details of the community supports that a person received in the month prior to admission.
Format:	Y/N
Codeset values:	Domestic assistance Social support Nursing care Allied health Personal care Meals Provision of goods & equipment Transport services Case management
Source data standard:	Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts-Australian Version

Admission information

Total length of stay in hospital

Definition:	The total length of patient's inpatient stay calculated from the date of admission to date of separation. This includes all coded episodes of care for the admission (e.g. acute care, rehabilitation, maintenance, palliative care etc)
Format:	Numeral
Codeset values:	Any valid numeral
Source data standard:	Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0

Length of stay of rehabilitation

Definition:	The total length of stay in the rehabilitation unit or service, or the SNAP rehabilitation care date where these is no rehabilitation specific unit (e.g. mixed acute and rehab ward).
Format:	Numeral
Codeset values:	Any valid number
Source data standard:	Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0

Suspension of rehabilitation

Definition:	The total number of rehabilitation treatment suspension occurrences during this admission.
Format:	Numeral
Codeset values:	Any valid number (0 where there is no suspension)
Source data standard:	Australasian Rehabilitation Outcomes Centre Inpatient Data Dictionary V4 for Analysts-Australian Version

Reason for rehabilitation

Definition:	The primary reason for a patient undergoing a rehabilitation episode of care.		
Format:	Coded text		
Codeset values:	*RST*	*Stroke*	Left Body Involvement, Right Body Involvement, Bilateral Involvement, No Paresis, Other Stroke
	RBD	*Brain dysfunction*	Non–Traumatic –Sub-arachnoid haemorrhage, Anoxic brain damage, Other non-traumatic brain dysfunction, Traumatic -Open Injury, Closed Injury.
	RNE	*Neurological conditions*	Multiple Sclerosis, Parkinsonism, Polyneuropathy, Guillian-Barre, Cerebral Palsy, Neuromuscular disorders, Other neurological conditions

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RSC	*Spinal cord dysfunction*	Non-Traumatic spinal cord dysfunction -Incomplete paraplegia, Complete paraplegia, Incomplete C1-4 quadriplegia, Incomplete C5-8 quadriplegia, Complete C1-4 quadriplegia, Complete C5-8 quadriplegia, Other non-traumatic spinal cord dysfunction, Traumatic spinal cord dysfunction - Incomplete paraplegia, Complete paraplegia, Incomplete C1-4 quadriplegia, Incomplete C5-8 quadriplegia, Complete C1-4 quadriplegia, Complete C5-8 quadriplegia, Other non-traumatic spinal cord dysfunction.
RAL	*Amputation of limb*	Single upper extremity above the elbow, Single upper extremity below the elbow, Single lower extremity above the knee, Single lower extremity below the knee, Double lower extremity above the knee, Double lower extremity above/below the knee, Double lower extremity below the knee, Partial foot, Other amputation not from trauma
RAR	*Arthritis*	Rheumatoid Arthritis, Osteoarthritis, Other Arthritis.
RPS	*Pain syndromes*	Neck pain, Back pain, Extremity pain, Headache, Multi-site pain, Other pain.
ROF	*Orthopaedic conditions - fractures,*	Includes: Fracture of hip -unilateral, Fracture of hip – bilateral, Fracture of shaft of femur, Fracture of pelvis, Fracture of knee, Fracture of lower leg or ankle or foot, Fracture of upper limb, Fracture of spine, Fracture of multiple sites, Other orthopaedic fracture.
ROR	*Orthopaedic conditions - replacements*	Includes: Hip replacement unilateral or bilateral, Knee replacement – unilateral or bilateral, Knee and hip replacement – same or different side, Shoulder replacement.
ROA	*Orthopaedic conditions – all other*	Soft tissue injury.
RCA	*Cardiac*	Following recent onset of new cardiac impairment, Chronic cardiac insufficiency, Heart and heart/lung transplant
RPU	*Pulmonary*	Chronic obstructive pulmonary disease, Lung transplant, Other pulmonary
RBU	*Burns*	Burns
RCD	*Congenital deformities*	Spina Bifida, Other Congenital deformities
ROI	*Other disabling impairments*	Lymphoedema, Conversion disorder, Other disabling Impairments – that cannot be classified into a specific group.
RMT	*Major multiple trauma*	Brain and spinal cord injury, Brain and multiple fracture/amputation, Spinal and multiple fracture/amputation, Other multiple trauma.
RDD	*Developmental disabilities*	Developmental disabilities (excluding Cerebral Palsy)
RDE	*Debility*	Re-conditioning following surgery, Reconditioning following medical illness, Cancer rehabilitation.

Source data standard:	Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0

Service delivery and interventions

Rehabilitation setting

Definition:	The type of patient for which a service is being provided, for example inpatient or outpatient.
Format:	Coded text
Codeset values:	1. Inpatient 2. Outpatient 3. Community
Source data standard:	Collection source - ieMR

Collaborative goal setting

Definition:	The completion of collaborative patient-centred goal setting to inform rehabilitation care and interventions
Format:	Coded text
Codeset values:	Yes No Type: Free text – character limited field

Intervention date

Definition:	The date that the service event commenced
Format:	DDMMYYY
Codeset values:	Any valid date
Source data standard:	Collection source - ieMR

Intervention type

Definition:	The type of intervention provided to a patient during a rehabilitation episode
Format:	Coded text
Codeset values:	1. Assessment and evaluation (including goal setting) 2. Education (knowledge, skills and self-management) 3. Risk Management 4. Intervention 5. Liaison and coordination
Source data standard:	Collection source - ieMR

Intervention duration

Definition:	The duration of clinical care activity provided to a person or group in the rehabilitation service that can be assigned (in whole or part) to an individual patient
Format:	Numeral, maximum 4 digits
Codeset values:	Valid duration recorded in minutes
Source data standard:	Collection source - ieMR

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Barriers to intervention

Definition:	Barriers to providing specific interventions to a person in the rehabilitation service by the healthcare professional.
Format:	Coded text
Codeset values:	1. Patient absent 2. Patient declined 3. Patient in pain 4. Patient unwell 5. Other patient reason 6. Staff-related barrier 7. Staff reprioritisation due to workload 8. Staff unavailable 9. Other staff reason
Source data standard:	Collection source - ieMR

Treating disciplines

Definition:	Details of the professions involved in the treatment of a patient in a rehabilitation setting, as represented by a code.
Format:	Coded text
Codeset values:	Any valid clinician code, grouped for reporting e.g. nursing, allied health professional, allied health assistant, medical
Source data standard:	Collection source - ieMR

Occasions of service

Definition:	The number of occasions of service provided to a patient during the rehabilitation episode.
Format:	Numeral
Codeset values:	Any valid numeral
Source data standard:	Collection source - ieMR

Intervention - mode of delivery

Definition:	The method of delivery of an intervention between a patient and a healthcare provider.
Format:	Coded text
Codeset values:	1. Face-to-face 2. Telephone 3. Telehealth 4. Chart only 5. Home visit
Source data standard:	Collection source - ieMR

Intervention – individual/ group

Definition:	Whether the intervention is provided to a patient in an individual on-to-one care setting, or in a group setting.
Format:	Coded text
Codeset values:	1. Individual 2. Group
Source data standard:	Collection source - ieMR

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Intervention – interprofessional

Definition:	Whether the individual intervention is provided by a single discipline or more than one discipline in an interprofessional manner.
Format:	Coded text
Codeset values:	1. Single discipline 2. Interprofessional
Source data standard:	Collection source - ieMR

Medication interventions

Definition:	A list of the medications administered during the rehabilitation episode, sorted by therapeutic class.
Format:	Coded text
Codeset values:	Any medication, classified for visualisation into therapeutic classes using the following categories: - Potassium and electrolytes - Insulin - Narcotics - Cytotoxic - Heparin and anticoagulants - Allergies and antibiotics - Other (all other medications)
Source data standard:	Collection source - ieMR

Outcomes

Goal attainment

Definition:	The attainment result of goals established on commencement in the rehabilitation setting
Format:	Coded text
Codeset values:	1. Goal met 2. Goal partially met 3. Goal not met
Source data standard:	Collection source - ieMR

Impairment

Definition:	Change/improvement in impairment at the end of rehabilitation episode
Format	TBA
Codeset values:	TBA
Source data standard:	Potential measures used in other datasets: AROC (ASIA Impairment Scale), UKROC (Northwic Park Dependency Scale), ICHOM (Simplified modified Rankin Scale Questionnaire), NSCISC (ASIA Impairment Scale), RIKSSTROKE (non-validated instrument), Paul Coverdell (modified Rankin Scale Questionnaire)

Change in functional status - total

Definition:	The change in FIM score (total), calculated by the FIM scores collected at the beginning of the rehabilitation episode and at the end of the rehabilitation episode for an individual patient.
Format:	Numeral
Codeset values:	Numeral between 18 and 126
Source data standard:	Australasian Rehabilitation Outcomes Centre (AROC) Inpatient Data Dictionary for Analysts (AU) V4

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Change in functional status - subscales

Definition:	The change in FIM subscale scores (motor and cognition), calculated by the FIM sub-scale scores collected at the beginning of the rehabilitation episode and at the end of the rehabilitation episode for an individual patient.
Format:	Numeral
Codeset values:	Motor subscale (sum of individual motor items): numeral between 13 and 91. Cognition subscale (sum of individual cognition items): numeral between 5 and 35.
Source data standard:	Australasian Rehabilitation Outcomes Centre (AROC) Inpatient Data Dictionary for Analysts (AU) V4

Activity and participation

Status: Routine clinical information

Definition:	Level of activity and participation obtained at the end of rehabilitation episode. *Note: Need to consider timing of this assessment given consumer experience of rehabilitation being a lifelong journey*
Format:	TBA
Codeset values:	TBA
Source data standard:	Potential measures used in other datasets: AROC (Employment status; Return to pre-impairment activities), UKROC (Mayo-Portland Adaptability Inventory), CIHI (Reintegration to Normal Living index), NSW BIRD (Mayo-Portland Adaptability Inventory; PROMIS-29), ICHOM (PROMIS-10), RHSCIR (Craig Hospital Inventory of Environmental Factors), NSCISC (Craig Handicap Assessment and Reporting Technique - short form), RIKSSTROKE (non-validated instrument)

Health related quality of life

Definition:	The impact of health or disease on quality of life; how well a person functions in their life and his or her perceived wellbeing in physical, mental, and social domains of health; value of health states (reference: Kirimi and Brazier, 2016)
Format:	TBC
Codeset values:	TBC
Source data standard:	Potential tools used in other datasets: EQ-5D, PROMIS, SF-36

Patient experience

Definition:	Information about the patient's perception of the experience of inpatient rehabilitation
Format:	TBC
Codeset values:	TBC
Source data standard:	TBC

Patient satisfaction

Definition:	A measure of a patient's overall satisfaction with the rehabilitation episode
Format:	TBC
Codeset values:	TBC
Source data standard:	TBC

Complications and adverse events

Definition:	A hospital-acquired complication (HAC) refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
Format:	Coded text
Codeset values:	1. Pressure injury 2. Falls resulting in fracture or intracranial injury 3. Healthcare associated infection 4. Respiratory complications 5. Venous thromboembolism

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	6. Renal failure 7. Gastrointestinal bleeding 8. Medication complications 9. Delirium 10. Persistent incontinence 11. Malnutrition 12. Cardiac complications
Source data standard:	Hospital acquired complications v3.1 Hospital-Acquired Complications (HACs) List - Specifications - Version 3.1 | Australian Commission on Safety and Quality in Health Care

Number of readmissions

Definition:	An avoidable hospital readmission occurs when a patient who has been discharged from hospital (index admission) is admitted again within 28 days, and the readmission is a) clinically related to the index admission, and b) has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission
Format:	Numeral
Codeset values:	Any valid numeral
Source data standard:	Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2020-2021 V1.0

Caregiver information and outcomes

Current caregiver status

Definition:	The current caregiver status of the person to take on the caregiving role after the rehabilitation episode
Format:	Coded text
Codeset values:	1. Yes, currently caregiver for this person 2. No, not currently caregiver for this person
Source data standard:	Collection source - ieMR

Caregiver capacity and willingness to care

Definition:	The physical, emotional, social, and psychological capacity and willingness to take on the planned caregiver role, as assessed early in the rehabilitation episode.
Format:	TBA
Codeset values:	TBA
Source data standard:	Suggested tool: Preparedness for Caregiving Scale (Henriksson et al 2013)

Caregiver preparedness

Definition:	Caregiver reflection on how prepared they were in taking on the caregiving role, as assessed after completion of the rehabilitation episode
Format:	TBA
Codeset values:	TBA
Source data standard:	Suggested tool: Preparedness for Caregiving Scale (Henriksson et al 2013)

Caregiver experience

Definition:	The caregiver's experience with the rehabilitation episode, as experienced by them (not as a proxy for the patient)
Format:	TBA
Codeset values:	TBA
Source data standard:	TBA – no tool identified.

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