Government of Western Australia
Department of Health

Admitted Subacute & Non-acute Care Data Collection

SANADC REFERENCE MANUAL 2016/2017



Inpatient and Mental Health Data Collections
Data Integrity Directorate
Purchasing and System Performance Division

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Contents

Abbreviations

Abbreviation	Definition
ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
AMHOCN	Australian Mental Health Outcomes and Classification Network
AN-SNAP	Australian National Subacute and Non-acute Patient Classification
AROC	Australasian Rehabilitation Outcomes Centre
AHSRI	Australian Health Services Research Institute
DSS	Data Set Specification
FIM	Functional Independence Measure
GEM	Geriatric Evaluation and Management
HCARe	Health Care and Related Information System
HMDC	Hospital Morbidity Data Collection
HMDS	Hospital Morbidity Data System
HoNOS 65+	Health of the Nation Outcomes Scale 65+
HSS	Health Support Services
IHPA	Independent Hospital Pricing Authority
METeOR	Metadata Online Registry
NHDD	National Health Data Dictionary
NHRA	National Health Reform Agreement
NOCC	National Outcomes and Casemix Collection
PAS	Patient Administration System
PCOC	Palliative Care Outcomes Collaboration
PSOLIS	Psychiatric Services Online Information System
QoCR	Quality of Care Register
RUG-ADL	Resource Utilisation Group – Activities of Daily Living
SANADC	Subacute and Non-acute Care Data Collection
TOPAS	The Open Patient Administration System
UMRN	Unit Medical Record Number
URN	Unit Record Number
WA	Western Australia
YTD	Year-to-date

SECTION 1: ABOUT THE COLLECTION

Overview

The Subacute and Non-Acute Care Data Collection (SANADC) is a specialised repository of important clinical and non-clinical information about admitted patients receiving the following types of care:

- Rehabilitation
- Geriatric Evaluation and Management (GEM)
- Psychogeriatric Care
- Palliative Care
- Maintenance Care

The repository is specifically set up to collect detailed subacute and non-acute care clinical assessments that assist in measuring the quality and efficacy of inpatient subacute and non-acute programs. These clinical assessments play an integral role in allocation of an Australian National Subacute and Non-acute Patient (AN-SNAP) classification to individual subacute and non-acute records.

The SANADC receives data from a variety of sources. The majority of demographic, admission, discharge and morbidity information is sourced from the Hospital Morbidity Data System (HMDS). While subacute and non-acute specific information is sourced from specialised systems such as Quality of Care Register (QoCR) and Psychiatric Services Online Information System (PSOLIS).

The Western Australian Department of Health are mandated by the peak Commonwealth funding body, the Independent Hospital Pricing Authority (IHPA), to submit a biannual data set containing all publicly funded admitted subacute and non-acute activity. IHPA utilise the submissions to classify all activity into AN-SNAP classes and calculate Activity Based Funding (ABF) for the State.

Purpose of the Collection

The SANADC provides WA Department of Health and IHPA with the necessary information for planning, allocating and evaluating subacute and non-acute care programs within Western Australia, in turn, IHPA determine the level of state funding under Activity Based Funding (ABF) arrangements.

The information housed in the SANADC is critical for classification to the AN-SNAP Classification which informs ABF calculations. Without complete and accurate clinical assessment data reported to the SANADC for subacute and non-acute episodes, health services could miss out on premium Commonwealth funding.

Other key purposes of the collection include provision of information for:

- Monitoring and assessing subacute and non-acute health service utilisation
- Epidemiological and medical research
- Data linkage

Definition of Subacute and Non-acute Care

Subacute care is defined as specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context and to the impairment of a body function or structure, activity limitation and/or participation restriction.

Subacute care consists of the following care types:

- Rehabilitation care
- Palliative Care
- Geriatric Evaluation and Management (GEM)
- Psychogeriatric care.

Non-acute care comprises of the following care type:

- Maintenance care

Scope of the Collection

The SANADC receives clinical data from both public and private sector health services. As the Collection is still in development a number of exclusions are applied to ensure compliance with mandatory reporting requirements, however additional data is still stored and monitored for future relevance.

The subacute and non-acute activity data that is currently in-scope for collection include:

- Admitted, publicly funded episodes in public hospitals
- Admitted, publicly funded episodes in private hospitals.

The subacute and non-acute activity data that is currently out-of-scope for collection includes:

- Admitted, privately funded episodes in private hospitals
- Hospitals operated by Australian Defence Force, correctional authorities and Australian external territories.

Subacute Care Data Collection Team

The SANADC is maintained by the Subacute Care Data Collection Team (SACDT) within the Data Integrity Directorate of WA Department of Health.

To ensure that SANADC remains valuable and relevant, the Team is responsible for:

- providing advice and support to data collectors at health service level to ensure complete and accurate reporting
- enforcing data quality and providing data quality education
- responding to regular and ad hoc data requests
- supporting data users internal and external to WA Health
- developing analytical tools
- maintaining metadata.

SANADC Reference Manual

This Manual provides direction and guidelines for hospitals regarding the submission of data and the definitions of required data elements.

The appendices in the SANADC Reference Manual provide further useful information and tools that may assist health services in understanding the scope and requirements for data collection.

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SECTION 2: CONTACTS AND KEY LINKS

Contact Details

Subacute Care Data Collection Team

Manager, Subacute & Non-acute Data Collection	Ph: (08) 9222 0266
Data submission	Ph: (08) 9222 2497 Email: sana.data@health.wa.gov.au
Data quality queries	Ph: (08) 9222 0266 Ph: (08) 9222 2497 Email: sana.data@health.wa.gov.au
Data extracts	Ph: (08) 9222 2497
Ad hoc data requests	Ph: (08) 9222 2497

Health Reform Division

Manager, Activity Based Funding and Management	Ph: (08) 9222 4402 Email: activity@health.wa.gov.au
Senior Project Officer	Ph: (08) 9222 4495 Email: activity@health.wa.gov.au

Subacute Community and Aged Care Directorate

Manager	Ph: (08) 9222 4306

Key Websites

State

WA Health
http://www.health.wa.gov.au

HMDS Reference Manual
http://www.health.wa.gov.au/healthdata/resources/hmds.cfm

Activity Based Funding (Western Australia)
http://www.health.wa.gov.au/activity/home/

National

Australian Health Services Research Institute (AHSRI)
http://ahsri.uow.edu.au

Australian Institute of Health and Welfare
METeOR (Metadata Online Repository)
National Health Data Dictionary (NHDD)
Australian Hospital Statistics
These and other publications/resources may be accessed from:
Web page: http://www.aihw.gov.au

Australian Mental Health Outcomes and Classification Network
Web page: http://amhocn.org/
E-mail: info@amhocn.org
Telephone: (02) 9840 3833
Facsimile: (02) 9840 3838

Australian Rehabilitation Outcomes Centre (AROC)
Web page: http://ahsri.uow.edu.au/aroc/index.html
E-mail: aroc@uow.edu.au
Telephone: (02) 4221 4411
Facsimile: (02) 4221 4679

Independent Hospital Pricing Authority
Information on Activity Based Funding may be obtained from:
Web page: http://www.ihpa.gov.au
E-mail: enquiries.ihpa@ihpa.gov.au
Telephone: (02) 8215 1100
Facsimile: (02) 8215 1111

METeOR
Admitted sub-acute and non-acute hospital care data set specification
http://meteor.aihw.gov.au/content/index.phtml/itemId/556874

WA Cancer and Palliative Network
Web page: http://www.healthnetworks.health.wa.gov.au/cancer/home/
E-mail: Palliativecare.CPCN@health.wa.gov.au
Telephone: (02) 8215 1100
Facsimile: (02) 8215 1111

Palliative Care Outcomes Collaboration
Web page: http://ahsri.uow.edu.au/pcoc/index.html
E-mail: tanya.pidgeon@uwa.edu.au
Telephone: 0467 720 453

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SECTION 3: DATA COLLECTION REQUIREMENTS

3.1 Care Type Specific Clinical Assessment Tools

For the majority of patients receiving subacute and non-acute care, the demographic, admission, discharge and morbidity information is captured in hospital Patient Administration Systems (PAS) and submitted to WA Department of Health via the HMDS. However, for the AN-SNAP classification and subsequent funding, sites are required to submit additional data items for each episode of subacute or non-acute care. As per the table below, the number of additional data items required depends on the Care Type.

	FIM Scores	Impairment Code	SMMSE	HoNOS 65+ Scores	RUG-ADL(s)	Phase(s) of Care
Rehabilitation	✓	✓				
Geriatric Evaluation & Management	✓	✓	✓			
Psychogeriatric				✓		
Palliative Care					✓	✓
Maintenance Care					✓	

All data items are to be collected on admission**.**

3.2 Rehabilitation Care

3.2.1 Definition

IHPA (2014a) defines Rehabilitation in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is always:

- *delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and*
- *evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must include negotiated goals within specified time frames and formal assessment of functional ability.*

3.2.2 Data Collection Requirements

For Rehabilitation Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Clinical Assessment Only Indicator
- FIM Assessment (18 data items)
- Impairment Code

3.3 Geriatric Evaluation and Management

3.3.1 Definition

IHPA (2014b) defines Geriatric Evaluation and Management (GEM) in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs, associated with age related medical conditions. Some examples of conditions in GEM care patients include a tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

GEM care is always:

- *delivered under the management of or informed by a clinician with specialised expertise in GEM care, and*
- *evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional and social needs of the patient, as well as include negotiated goals within indicative time frames and formal assessment of functional ability.*

It includes care provided:

- in a geriatric evaluation and management unit
- in a designated geriatric evaluation and management program
- under the principal clinical management of a geriatric evaluation and management physician
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

GEM care is generally applicable to older patients however, younger adults with clinical conditions generally associated with old age can also be classified under this care type.

3.3.2 Data Collection Requirements

For GEM Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Clinical Assessment Only Indicator
- FIM Assessment (18 data items)
- Standardised Mini-Mental State Examination (18 data items) (where applicable)
- Impairment Code

3.4 Psychogeriatric Care

3.4.1 Definition

IHPA (2014c) defines Psychogeriatric Care in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance. The disturbance is caused by mental illness, age related organic brain impairment or a physical condition.

Psychogeriatric care is always:

- *delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and*
- *evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional and social needs of the patient, as well as include the negotiated goals within indicative time frames and formal assessment of functional ability.*

It includes care provided:

- in a Psychogeriatric care unit
- in a designated Psychogeriatric care program
- under the principal clinical management of a Psychogeriatric physician
- in the opinion of the treating doctor, when the principal clinical intent of care is Psychogeriatric care.

3.4.2 Data Collection Requirements

For Psychogeriatric Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Clinical Assessment Only Indicator
- HoNOS 65+ Scores (12 data items)

3.5 Palliative Care

3.5.1 Definition

IHPA (2014d) defines Palliative Care in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- *delivered under the management of or informed by a clinician with specialised expertise in palliative care, and*
- *evidenced by an individualised multidisciplinary assessment and management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional, social and spiritual needs of the patient, as well as include negotiated goals.*

It includes care provided:

- in a palliative care unit
- in a designated palliative care program
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

3.5.2 Data Collection Requirements

For Palliative Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Clinical Assessment Only Indicator
- Palliative Care Phase Start Date(s)
- Palliative Care Phase End Date(s)
- Palliative Care Phase Type(s)
- RUG-ADL Scores (4 data items)

3.6 Maintenance Care

3.6.1 Definition

Maintenance care is non-acute care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting (e.g. at home, or in a residential aged care service, by a relative or carer) that is unavailable in the short term.

Types of maintenance care include:

- care and support of a person in an inpatient setting whilst the patient is awaiting transfer to residential care or alternate support services or where there are factors in the home environment (physical, social, psychological) which make discharge to home inappropriate for the person in the short term
- psychogeriatric patients receiving respite or non-acute care
- patients in receipt of care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment (e.g. at home, in a nursing home, by a relative or with a guardian) is unavailable in the short term (respite care)
- care and support of a person with a functional impairment for whom there is no multi-disciplinary program aimed at improvement of functional capacity
- awaiting an Aged Care Service: Where a patient who has been assessed as requiring more intensive day-to-day care than that which can be provided in their home environment and are awaiting placement in a Nursing Home or Hostel but whose length of stay is not exceeding 35 days.

3.6.2 Data Collection Requirements

For maintenance care episodes the following non-acute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Clinical Assessment Only Indicator
- Type of Maintenance
- RUG-ADL scores (4 data items)

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SECTION 4: DATA SUBMISSION REQUIREMENTS

4.1 Data Source Systems

Depending on the Care Type there are number of different information systems that facilitate electronic data collection.

For reliability purposes, all demographic, admission, discharge and morbidity information for subacute and non-acute episodes are sourced directly from the Hospital Morbidity Data Collection after they have been through the rigorous HMDS data quality cycle. The clinical assessment information for subacute/non-acute episodes, on the other hand, is collected in and sourced from specialised information systems.

The following section outlines the various information systems and applications available for collection of data for subacute and non-acute episodes.

4.1.1 Hospital Morbidity Data System

The HMDS is one of the largest data collections managed by the Department of Health. This repository is comprised of more than 21,000,000 electronic inpatient records dating back to 1970. Under the *Health Services Act 2016*, the Department of Health mandates all public and private hospitals to submit complete, accurate and timely admitted activity data to the HMDS in accordance with agreed data management protocols.

The HMDS is the source system for the administrative elements of a subacute or non-acute episode. Although, administrative information such as demographic, admission and discharge information are often entered into specialised subacute information systems and applications, the data stored in the HMDS is regarded as the 'cleanest' and therefore most reliable.

For further information on the HMDS, please refer to the following web address: http://www.health.wa.gov.au/healthdata/resources/hmds.cfm.

4.1.2 Quality of Care Register

The Quality of Care Register (QoCR) is a secondary patient administration system that enables hospitals with public designated rehabilitation and GEM wards to enter specific clinical information to meet their reporting requirements to the Australasian Research Outcomes Centre (AROC). AROC utilise the data for national benchmarking and clinical improvement purposes.

The FIM and Impairment data entered into QoCR is also integral to the classification and funding of Rehabilitation and GEM episodes using the AN-SNAP classification.

On a weekly basis, SANADC extracts FIM and Impairment data from QoCR. Using the hospital identifier and account number, the FIM scores and Impairment data are linked to the HMDS inpatient record to create a complete subacute record that can be assigned an AN-SNAP group and subsequently funded under ABF.

QoCR is only available in certain hospitals with designated rehabilitation and GEM wards. Sites equipped to enter GEM and Rehabilitation data in QoCR include:

Public
Albany Hospital
Armadale/Kelmscott District Memorial Hospital
Bentley Hospital

Private
St John of God – Mt Lawley

Bunbury Hospital
Busselton Hospital
Fiona Stanley Hospital
Fremantle Hospital & Health Service
Kalamunda District Community Hospital
Kalgoorlie Hospital
Osborne Park Hospital
Sir Charles Gairdner Hospital
Swan District Hospital
Royal Perth Hospital

4.1.3 Psychiatric Services Online Information System

The PSOLIS is a dedicated mental health patient administration system designed to collect demographic, admission, discharge, service event, morbidity and treatment information on patients/clients receiving care in public mental health services.

For all Psychogeriatric episodes, the Psychiatric Services Online Information System (PSOLIS) captures HoNOS 65+ information. This information is directly entered into PSOLIS by the reporting health services. In turn SANADC, receives an automated weekly extract from PSOLIS containing HoNOS 65+ information. Using the hospital identifier and account number, the HoNOS 65+ scores are linked to the HMDS inpatient record to create a complete subacute record.

PSOLIS is only available in public mental health services, therefore no HoNOS 65+ is sourced from any private hospitals at this time.

4.1.4 webPAS Subacute Module

In 2016, the webPAS Subacute Module will be available to webPAS sites. The module will enable users to enter the required data items for AN-SNAP grouping thus meeting the mandatory reporting obligations. The module is accessible via the Admissions module and provides dedicated data entry screens for each subacute and non-acute care type.

4.1.5 ePaLCIS

In 2016, the electronic Palliative Care Information System (ePaLCIS) will be rolled-out across the State to allow specialised palliative care services to comprehensively record and report on the palliative care activity in various settings. ePaLCIS will enable health services to capture the clinical assessment requirements for AN-SNAP classification in addition to allowing willing health services to participate in the Palliative Care Outcomes Collaboration (PCOC) which provides its participants with national benchmarking capability.

4.1.6 HCARe

In 2016, HCARe will have inbuilt functionality to facilitate capture of RUG-ADL information for Maintenance Care episodes.

4.2 Guidelines for Submission of Data

4.2.1 Methods of Submission

Data can only be submitted to SANADC in an electronic format.

Please note that the SANADC is a developing data set that is still endeavouring to maximise sourcing of data from health services. Data extraction and submission protocols may change during 2016/2017 as the SANADC processes are refined.

4.2.1.1 Automated Extraction by SANADC

Where data is entered into an established patient administration system that is supported via Health Support Services (HSS), site level submission is not required. The SANADC Team will automatically extract data from these systems at scheduled intervals. Automatic extraction is/will occur from the following patient administration systems in 2016/2017:

- ePaLCIS (Palliative Care requirements only)
- HCARe (Maintenance Care requirements only)
- PSOLIS (Psychogeriatric Care requirements only)
- QoCR (Rehabilitation and GEM requirements only)
- webPAS Subacute Module (All Care Type requirements)

4.2.1.2 Submission of Data Files

Subacute/non-acute services that utilise an alternate or in-house information system for collection of data, are required to submit data in an electronic format that is compliant with the Subcute/Non-acute Care ABF Technical Specifications for Submission of Data. Please contact the SANADC Team to obtain a copy of the latest Technical Specifications.

Data files are to be sent to the SANADC Team via email: sana.data@health.wa.gov.au.

4.2.2 Due Dates for Submission

For data that can be automatically extracted from the above patient administration systems that are supported via HSS, there are no due dates. However, to ensure timely and complete extraction of data for reporting purposes, health services should perform regular data entry and avoid 'batching'.

For sites that submit data files, data for the preceding month must be submitted to SANADC by the 7th working day of the month. For example, all completed data for July must be submitted to SANADC by the 7th August.

4.2.3 Penalties for Non-Compliance

Under the terms of the IHPA's proposed funding arrangements from 1 July 2016, any subacute/non-acute episode that cannot be successfully grouped under the AN-SNAP classification, whether it be due to omission or failure to successfully group, will default to funding under the Australian Refined – Diagnosis Related Group (AR-DRG) classification.

Every effort should be made to ensure that every episode of subacute and non-acute activity can be successfully grouped to an AN-SNAP class thus attracting premium Commonwealth funding that better matches the true cost of delivering subacute/non-acute care.

SECTION 5: DATA QUALITY AND ERROR CORRECTION

5.1 What is Data Quality?

Data Quality occurs when information is:

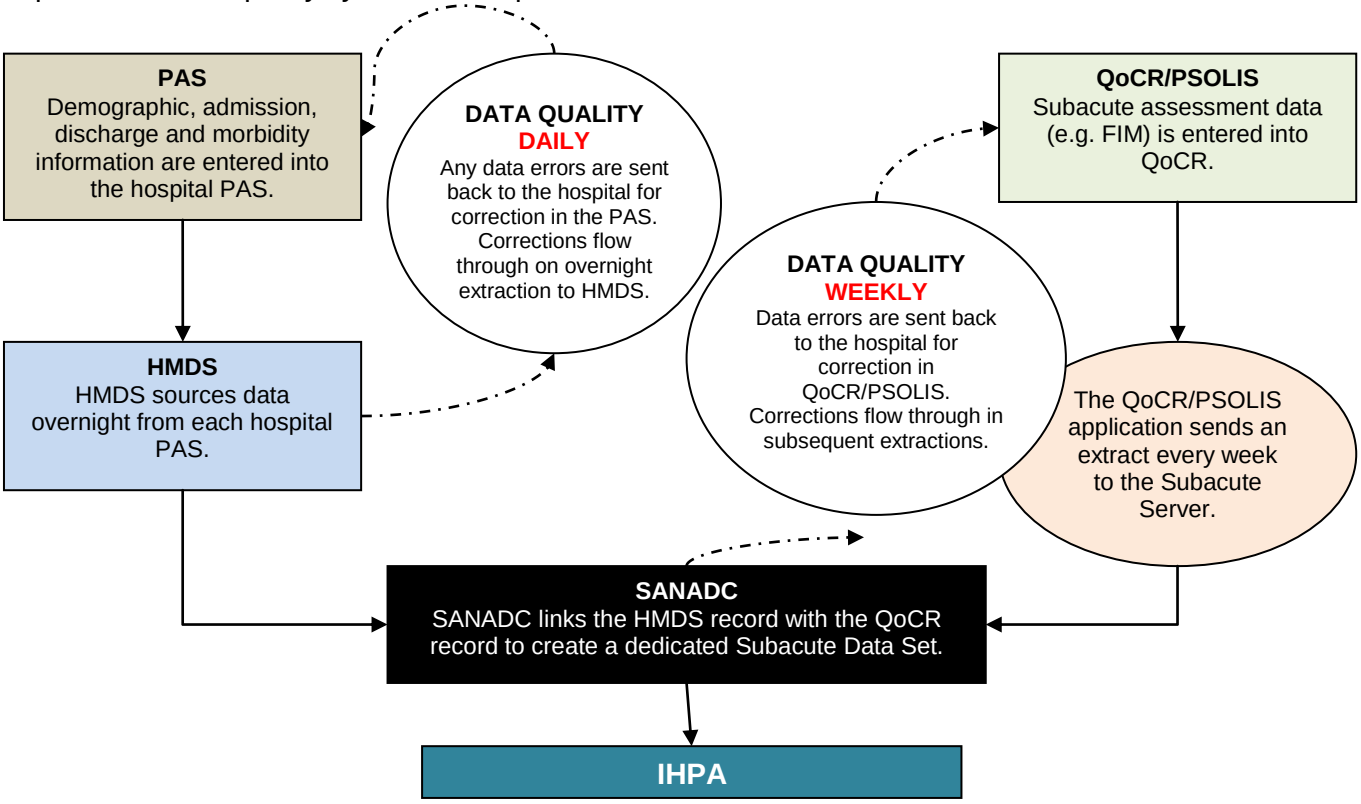
- accurate and precise as much as possible
- captured in a consistent format
- conforms to standardised business rules
- relevant and necessary
- available
- timely
- transmitted and stored securely.

Data quality is important in any data collection, however it is particularly important within the SANADC as even the slightest error or omission in a single data item can render the record invalid for reporting and funding under the AN-SNAP Classification. Effectively, if a record is to pass through the SANADC for reporting and funding it must be perfect!

5.2 Data Quality Cycle

Although data submission methods and sources may vary from site to site, the Data Quality Cycle is the same for all reporting services.

There are two data cleansing processes that occur for data submitted to SANADC. The first process concerns data that is submitted to the HMDS. This data relates to demographic, admission, discharge and morbidity information. This data undergoes the HMDS Data Quality Cycle. The second process concerns the subacute clinical assessment data items (i.e. FIM, Impairment Type, HoNOS 65+, Phase of Care and RUG-ADL). This data undergoes the SANADC Data Quality Cycle. The following flow diagram depicts both data quality cycles for complete subacute records:



5.2 Data Quality Edits

Data quality errors that are sent back to the responsible site are called Data Quality Edits. Edits consist of a set of rules or parameters for what makes a record wrong, invalid or inconsistent. For example, the rules of a particular edit might say that if the date entered in the Assessment Date field is before the Admission Date then the record is in error due to inconsistency between dates.

Data Quality Edits each have an Edit Code or Edit Message that helps the user determine what is wrong with the record. In some cases, the user may need to refer to the precise Edit Logic to isolate the fields that could be causing the edit to trigger.

For the HMDS Data Quality Cycle, there are more than 440 data quality edits screening the demographic, admission, discharge and morbidity information of a record. For the SANADC Data Quality Cycle, there are 43 data quality edits that exclusively screen the integrity of subacute clinical assessment data.

Please refer to *Appendix 4: SANADC Data Quality Edits* for detailed descriptions of all data quality edits and associated edit logic. This listing is useful in addressing data quality errors listed in Data Quality Edit Reports (see 5.4 Data Quality Edit Reports).

5.3 Types of Data Quality Edits

There are seven groups or classes of Data Quality Edits for subacute data which are focused primarily on the Care Type specific clinical assessment tool:

- FIM (error series 1XXX)
- Impairment Type (error series 2XXX)
- HoNOS 65+ (error series 3XXX)
- RUG-ADL (error series 4XXX)
- Phase of Care (error series 5XXX)
- Maintenance (errors series 6XXX)
- Assessment/Other (error series 9XXX).

Please note that these classes do not include the Data Quality Edits performed on the data items sourced from the HMDS record. As per the *5.2 Data Quality Cycle*, data sourced from HMDS has already undergone data quality validations and correction by the time it reaches the SANADC.

If a subacute or non-acute record triggers a data quality edit from any error class, it should be treated as a critical error and addressed as a matter of priority. A record in critical error will not be reported as the errors within the record prohibit successful grouping to a valid AN-SNAP classification. It is important to note that where a record cannot be grouped to AN-SNAP, the health service may not be financially reimbursed or may be reimbursed at a reduced cost weight under the Australian Refined Diagnosis Related Group classification.

5.4 Data Quality Edit Reports

5.3.1 Definition

Data Quality Edit Reports are a Microsoft Excel spreadsheet that provides a record level listing of all year-to-date (YTD) errors in reported subacute/non-acute information.

SANADC generates these reports weekly and sends them via e-mail to a subacute representative at each hospital with one or more designated subacute wards or programs.

The purpose of these reports is to provide hospitals with a listing of errors relating to record level subacute data that has been submitted to SANADC and provide sufficient reference information to enable subsequent correction.

5.3.2 Report Structure

A standard Data Quality Edit Report will consist of the following tabs:

- Summary Report: This provides a two table overview of the number of errors by care type and number of errors by Edit.
- Care Type Reports:
    - GEM care: This provides a record level listing of all the GEM records that have triggered one or more errors. This tab will only exist if there are GEM records in error.
    - Rehabilitation care: This provides a record level listing of all the Rehabilitation care records that have triggered one or more errors. This tab will only exist if there are Rehabilitation care records in error.
    - Maintenance care: This provides a record level listing of all the Maintenance care records that have triggered one or more errors. This tab will only exist if there are Maintenance records in error.
    - Palliative care: This provides a record level listing of all the Palliative care records that have triggered one or more errors. This tab will only exist if there are Palliative care records in error.

The Summary Report tab will appear on all Data Quality Edit Reports. However, a tab by care type (GEM, Rehabilitation care etc) will only exist if there are records in error for that care type. Therefore, the fewer tabs appearing in a report means greater data quality.

A single record can trigger one or more errors, so where a record appears across multiple lines this indicates that there are multiple errors attached to the one record. Where this occurs refer to the Edit code and message and address accordingly.

5.3.3 Understanding Data Quality Edit Reports

5.3.3.1 Summary Report

This report is provided for reference purposes and to facilitate any trending you may wish to perform over time.

5.3.3.2 Care Type Report

The format of a Care Type Report is the same for all subacute care types. A Care Type report will consist of the following fields:

Field	Field Description
Hospital Number	The unique identifier for the hospital
Client Identifier	The unique identifier assigned by the hospital (e.g. UMRN, URN etc) for the patient.
Event Identifier (ID)	The unique event identifier assigned by the HMDS to this episode. Generally not useful for hospital purposes but aids SANADC in efficiently identifying a unique episode should a hospital have any queries.
Account Number	The unique account identifier assigned by hospital to identify the episode.
Admission Date	The date upon which the episode commenced.
Separation Date	The date upon which the episode ended.
Assessment Date	The date upon which the relevant clinical assessment (FIM, HoNOS 65+, RUG-ADL, Phase of Care etc) was performed.
Care Type	The type of care the patient received during their episode of care.
Ward	The ward the patient was separated from upon completion of their episode of care.
Edit Code	The unique code used to identify a type of edit.
Edit Description	The description of the edit or error attached to the record. The edit description is a standardised message. Although descriptive, it may not provide all the information needed to identify the particular fields in error. The reviewer may need to refer to the *Appendix 6: SANADC Data Quality Edits* to reference the specific business rules and fields responsible for triggering the edit.
Last Amended HE Number	The unique employee or user number of the last person to edit the record. It must not assumed that the last HE number attached to the record is the person responsible for making the error. Infact, if the record is corrected this field will be updated to reflect the person who corrected it.
Last Amended Date	The date the record was last amended. Please note that amended does not mean corrected, it simply means the last date upon which any changes (right or wrong) were made to the record.
Comments	This is a free text field available to both hospital and SANADC team to provide any specific information or explanation in relation to a particular error.

5.3.4 How to address a Data Quality Edit Report

Once you have a good understanding of the content of the Data Quality Edit Report then you can take steps towards referencing and addressing data quality edits.

The following is a suggested protocol for addressing errors listed in your Data Quality Edit Report:

1. Identify the Edit Code and Edit Description for a specific record in the Data Quality Edit Report.
2. Refer to the Edit Logic (as specified in *Appendix 6: SANADC Data Quality Edits*) and make a note of the specific fields that are referenced in the Edit Logic.
3. Look up record in the information system (e.g. QoCR).
4. Identify fields in the information system that are referenced in the Edit Logic.
5. Update or correct relevant fields.
6. Document any changes made or comments in the Comments field of the Data Quality Edit Report.
7. Once all edits have been reviewed and/or commented, send the Data Quality Edit Report back to SANADC.

All errors within a Data Quality Edit Report should be addressed in a timely manner (preferably within the week). This is not only to ensure efficient and accurate reporting of subacute numbers but to minimise site level administrative burdens associated with record retrieval and follow-up.

5.3.5 Frequency of Data Quality Edit Reporting

Data Quality Edit Reports are generated by SANADC at the start of every business week and sent to the respective subacute hospitals, wards or programs. To ensure error numbers remain low and that sites can efficiently address error records as close to patient separation as possible, it is strongly advised that all errors are addressed within the week before the next weekly reporting cycle commences.

5.3.6 Data Quality Edit Logic

A detailed listing of the edit logic for each edit that may appear in your Data Quality Edit Report is available in *Appendix 6: SANADC Data Quality Edits*. At first, it can take some time and concentration to understand why an edit is being triggered. However, frequent review of Data Quality Edit Reports will improve your efficiency in addressing data quality errors.

As AN-SNAP grouping is dependent on accurate completion of all necessary data items, there are three Golden Rules a data enterer must be mindful of:

1. If a field is blank or missing, it will trigger an error.
2. If a field is inconsistent with admission and separation dates, it will trigger an error.
3. If a field is outside the range of acceptable values for that field, it will trigger an error.

5.3.7 Providing Feedback about Data Quality Edit Reports

Data Quality Edit Reports are a communication tool that supports two way feedback. If you believe there are any deficiencies, ambiguities or problems with the format, structure or content of your Data Quality Edit Report please do not hesitate to contact SANADC with your feedback. Contact details for SANADC can be found in Section 2: Contacts and Key Links.

SECTION 6: UNDERSTANDING DATA ELEMENT DEFINITIONS

6.1 Overview

This section provides specific information about every data element captured in the SANADC, including definitions, permitted values, applicable business rules and practical data collection information.

Data is analysed across Australia, it is important that the same definitions are used for terms such as hospital, patient, admission and discharge. In most instances, the terms used in this manual are consistent with those used in the National Health Data Dictionary (NHDD) or the Admitted Subacute and Non-Acute Hospital Care Data Set Specification, available on METeOR. METeOR is an AIHW website which contains national metadata standards for health, housing and community services statistics and information.

This section provides definitions for each data element reported to SANADC and is divided into two sections:

- Non-Clinical Data Element Definitions
- Clinical Data Element Definitions.

The Non-Clinical Data Element Definitions incorporate all data elements that are deemed to be non-clinical and would generally be captured through normal administrative processes.

The Clinical Data Element Definitions incorporate all data elements that would normally be captured by clinical personnel during the episode for the purpose of clinical patient care and management.

Within both sections, the data element definitions are listed alphabetically.

6.1.1 Data Element Definition Format

A standardised format has been applied to each data element. This format ensures that relevant information is presented consistently and efficiently to the reader. The following provides a definitional overview of the format:

Data Element Title

Specification

Definition:	*Specifies the definition of the data element.*		
METeOR reference:	*Specifies the six-digit data item number of the equivalent data item in the NHDD or relevant Data Set Specification (DSS). This field is hyperlinked for ease of reference.*		
Field size	*Specifies the size of the field for submission to SANADC*	**Layout**	*Specifies the format of the field for submission to SANADC*
Location	*Specifies the type of record in which this data element should be located or captured.*		
Reported by	*Specifies the type of facility that is required to collect and report the data element.*		

Reported for	*Specifies the context or conditions in which this data element is required to be collected and reported.*
Permissable values	*Specifies the permissable values to be entered. The term 'permissable values' may also be known as 'data domain'. Where there are a large number of permissible values such as a reference table or list, the reader is referred to the Appendices.*
Reporting Guide	*Specifies the business rules and guidelines for collection of the data element.* **Valid Values** *Specifies the permissible values and the definitions of the permissable values for the data element.*
Validations	*Specifies the data quality edits/validations that are triggered when there are anomalies or omissions in the data reported for this data element.*
Related Items	*Specifies any related data elements or references or documentation that refer to this data element that may support user understanding and interpretation.*

Administration

Purpose	*Specifies the purpose for collecting this data element.*
Principal data users	*Specifies who the principal users of data reported for this data element.*
Collection start	*Specifies the commencement date for collection of data for this data element.*
Data available	*Specifies the reporting periods/time frames for which data is available for this data element.*

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SECTION 7: NON-CLINICAL DATA ELEMENT DEFINITIONS

Account/Admission Number

Specification

Definition The unique identifier of a hospital episode of care that may be used for billing.

METeOR reference 499778 (WA Health)

Field size 18 **Layout** NNNNNNNNNNNNNNNNNN
Right justified with leading zeros.

Location HMDC Record
Subacute Record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute/non-acute care

Reported for For each episode of admitted care where the Care Type is:

22 – Rehabilitation Care
23 – Palliative Care
24 – Psychogeriatric Care
25 – Maintenance Care
29 – Geriatric Evaluation and Management

Permissable values Alpha/numeric combination up to 12 characters

Reporting guide Account/admission number is unique to the admitted episode of care. If a patient changes care type within an admitted episode, each admitted instance for a specific care type will be assigned a unique account or admission number.

For example:

Patient is formally admitted on 1 January 2017 and formally discharged on 15 February 2017. During this admission, the patient has the following care type changes generating four unique account/admission numbers corresponding to the care type:

Admission Date	Separation Date	Care Type	Account number
1 Jan 2017	3 Jan 2017	Acute	1234567
3 Jan 2017	30 Jan 2017	Rehabilitation	1234568
30 Jan 2017	5 Feb 2017	Acute	1234569
5 Feb 2017	15 Feb 2017	Rehabilitation	1234510

Validations All data quality performed on this data item is incorporated in the HMDC data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

The SANADC may identify is discrepancies or duplication of Account Numbers and will contact the responsible site for follow-up and subsequent correction.

Related Items	None specified.

Administration

Purpose	To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.
Principal data users	WA Department of Health
Collection start	1 July 2012
Data available	2012-13, 2013-14, 2014-15
Definition source	WA Department of Health

Admission Date

Specification

Definition The date on which an admitted patient commences an episode of care that can be formal or statistical.

METeOR reference 269967

Field size 8 **Layout** DDMMYYYY

Location
HMDC Record
Subacute Record

Reported by
Public hospitals
Private hospitals that provide publicly funded subacute/non-acute care

Reported for For each episode of admitted care where the Care Type is:

22 – Rehabilitation Care
23 – Palliative Care
24 – Psychogeriatric Care
25 – Maintenance Care
29 – Geriatric Evaluation and Management

Permissable values DDMMYYYY

Reporting guide The admission date can be the data of formal admission or the date the patient change from one care type another, commonly called a statistical admission or care type change.

Formal Admission

- A formal admission is an administrative process that initiates a record of the patient's treatment accommodation within a hospital.
- The admission date for a formal admission will be the date the hospital commenced treatment and accommodation of the patient.

Statistical Admission

- A statistical admission is an administrative process that occurs within an episode of care and captures the commencement of a particular type of care (care type).
- The admission date for a statistical admission will be the date the patient commenced a particular care type.

Often subacute and non-acute patients move between care types (acute → subacute → non-acute) with a single hospital stay. When this occurs there will only be one formal admission date but there can be many statistical admission dates depending on how many care type changes have occurred.

Validations	All data quality performed on this data item is incorporated in the HMDC data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.
Related Items	None specified

Administration

Purpose	To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.
Principal data users	WA Department of Health
Collection start	1 July 2012
Data available	2012-13, 2013-14, 2014-15
Definition source	WA Department of Health

Assessment Date

Specification

Definition	The date on which the patient was assessed against the functional tool associated with the patient's subacute/non-acute care type.
METeOR reference	Not applicable
Field size	8 **Layout** DDMMYYYY
Location	Subacute Record
Reported by	Public hospitals Private hospitals that provide publicly funded subacute/non-acute care
Reported for	For each episode of admitted care where the Care Type is: 22 – Rehabilitation Care 23 – Palliative Care 24 – Psychogeriatric Care 25 – Maintenance Care 29 – Geriatric Evaluation and Management
Permissable values	DDMMYYYY
Reporting guide	Rehabilitation and GEM patients are assessed against the FIM instrument. Psychogeriatric patients are assessed against the HoNOS 65+ Scale and Palliative and Maintenance patients are assessed against the RUG-ADL tool. The Assessment Date must reflect the date upon which the patient was assessed against the relevant functional tool. The Assessment Date must be between the Admission Date and the Separation Date. An Assessment Date must be captured on admission to the subacute or non-acute care type. For patients who move back and forth between care types (e.g. acute → subacute → acute → subacute), there will more than one Assessment Date recorded corresponding to each episode of subacute/non-acute care. For Palliative Care episodes, there must be a RUG-ADL Assessment Date reported for each Phase of Care. For Rehabilitation and GEM patients assessed against the FIM instrument, the Assessment must be completed within 72 hours of admission unless the patient has been admitted for assessment only.
Validations	The Assessment Date is a subacute/non-acute specific data element that is not included in the HMDC. All data validation on this data element is performed separately and data discrepancies are reported directly to the reporting ward.

This data element is subject to the following validations:

Edit No.	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1002	FIM assessment date is missing	Critical
1003	FIM assessment date is prior to admission date	Critical
1004	FIM assessment date is after separation date	Critical
1005	FIM assessment is not within 72 hours of the start of the episode of care	Critical
3002	HoNOS 65+ assessment date is missing	Critical
3003	HoNOS 65+ assessment date is prior to admission date	Critical
3004	HoNOS 65+ assessment date is after separation date	Critical
4003	RUG-ADLK assessment date is missing for maintenance episode	Critical
4004	RUG-ADL assessment date is prior to admission date for maintenance episode	Critical
4005	RUG-ADL assessment date is after the separation date for maintenance episode	Critical
5010	RUG-ADL assessment date is before phase of care start date	Critical
5011	RUG-ADL assessment date is after phase of care end date	Critical
5014	RUG-ADL assessment date is missing for palliative phase	Critical
5015	RUG-ADL phase assessment date is prior to admission date for palliative episode	Critical
5016	RUG-ADL phase assessment date is after the separation date for palliative episode	Critical

Related Items None specified

Administration

Purpose To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users WA Department of Health

Collection start 1 July 2012

Data available 2012-13, 2013-14, 2014-15

Definition source WA Department of Health

Client Identifier – Unit Medical Record Number

Specification

Definition	Person identifier unique within an establishment
METeOR reference	290046
Field size	10 **Layout** Alphanumeric up to 10 characters
Location	HMDC Record Subacute Record
Reported by	Public hospitals Private hospitals that provide publicly funded subacute/non-acute care
Reported for	For each episode of admitted care where the Care Type is: 22 – Rehabilitation Care 23 – Palliative Care 24 – Psychogeriatric Care 25 – Maintenance Care 29 – Geriatric Evaluation and Management
Permissable values	Alpha/numeric combination up to 10 characters
Reporting guide	The Client Identifier can be alphanumeric or numeric up to a maximum of 10 characters. The year number should not form any part of the Client Identifier. Pseudonyms for the Client Identifier include Unit Medical Record Number (UMRN) or Unit Record Number (URN). The same Client Identifier is retained by the hospital for the patient for all admissions within a particular hospital.
Validations	All data quality performed on this data item is incorporated in the HMDC data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.
Related Items	None specified.

Administration

Purpose	To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.
Principal data users	WA Department of Health
Collection start	1 July 2012

Data available	2012-13, 2013-14, 2014-15
Definition source	WA Department of Health

Clinical Assessment Only Indicator

Specification

Definition An indicator of whether an episode of admitted patient care resulted in the patient undergoing a clinical assessment only, as represented by a code.

METeOR reference 550492

Field size 1 **Layout** N

Location Subacute Record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute/non-acute care

Reported for For each episode of admitted care where the Care Type is:

22 – Rehabilitation Care
23 – Palliative Care
24 – Psychogeriatric Care
25 – Maintenance Care
29 – Geriatric Evaluation and Management

Permissable values
1 – Yes (Assessment Only)
2 – No
9 – Unknown

Reporting guide If valid value = 1 – Yes (patient assessed by clinical team but no further treatment or intervention was provided), then the applicable Assessment is NOT mandatory.

> An episode of care is regarded as 'assessment only' if a patient was seen for clinical assessment only and no treatment or further intervention was planned by the assessing clinical team.
>
> Where a patient is 'assessment only', the clinical team should assess whether the patient qualifies for the subacute or non-acute care type allocation based on ARDT Policy admission criteria.

If valid value = 2 – No (patient assessed by clinical team and further treatment or intervention was provided), then the applicable Assessment IS mandatory.

Valid Values

1 – Yes

This category should be used when the patient undergoes a clinical assessment only and no further treatment or intervention is provided.

These episodes are usually of short duration, normally less than 24 hours.

2 – No

This category should be used when the patient undergoes a clinical assessment and further treatment or intervention is provided that is consistent with the minimum requirements for the Care Type as defined in the ARDT Policy.

3 – Unknown

This category should be used when it is not known whether the episode of admitted care resulted in the patient undergoing a clinical assessment only.

Validations

The Clinical Assessment Only Indicator is a subacute/non-acute specific data element that is not included in the HMDC. All data validation on this data element is performed separately and data discrepancies are reported directly to the reporting ward.

This data element is subject to the following validations:

Edit No.	Edit Message	Edit Severity
9000	Assessment only answer is missing	Critical
9001	Assessment only answer is invalid	Critical

Related Items

None specified.

Administration

Purpose

To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users

WA Department of Health

Collection start

1 July 2012

Data available

2012-13, 2013-14, 2014-15

Definition source

WA Department of Health

Establishment

Specification

Definition	A unique four-digit number that is assigned globally by HMDS to each establishment that is required to report admitted activity information to the HMDS. The Establishment Code is an identifier for a reporting hospital.
METeOR reference	269973
Field size	4 **Layout** NNNN
Location	HMDC Record Subacute Record
Reported by	Public hospitals Private hospitals that provide publicly funded subacute/non-acute care
Reported for	For each episode of admitted care where the Care Type is: 22 – Rehabilitation Care 23 – Palliative Care 24 – Psychogeriatric Care 25 – Maintenance Care 29 – Geriatric Evaluation and Management
Permissable values	See the HMDS Manual for full list of Establishment Codes
Reporting guide	Please refer to the latest version of the HMDS Manual for a list of the valid hospital and health services and for detailed information on how Establishment Codes are allocated.
Validations	All data quality performed on this data item is incorporated in the HMDC data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.
Related Items	None specified.

Administration

Purpose	To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.
Principal data users	WA Department of Health
Collection start	1 July 2012
Data available	2012-13, 2013-14, 2014-15

Definition source WA Department of Health

Separation Date

Specification

Definition The date on which an admitted patient completes an episode of care. The patient can be formally or statistically discharged from hospital. If a patient dies in hospital, the separation date is the date of death.

METeOR reference 270025

Field size 8 **Layout** DDMMYYYY

Location HMDC Record
Subacute Record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute/non-acute care

Reported for For each episode of admitted care where the Care Type is:

22 – Rehabilitation Care
23 – Palliative Care
24 – Psychogeriatric Care
25 – Maintenance Care
29 – Geriatric Evaluation and Management

Permissable values Today's date or a valid date in the past.

Reporting guide Enter the full date of separation, including leading zeros where necessary.

If an admitted patient is on leave but does not return after 7 days the patient is then formally discharged on the 7th day, and the preceding days are counted as leave days.

Formal Separation/Discharge

- A formal separation/discharge is an administrative process that ceases a record of the patient's treatment and accommodation within a hospital.
- The Separation Date for a formal separation/discharge will be the date the hospital completed treatment and accommodation of the patient.

Statistical Separation/Discharge

- A statistical separation/discharge is an administrative process that occurs within an episode of care and captures the end date the patient received a particular type of care (Care Type).
- The Separation Date for a statistical admission will be the date the patient completed a particular Care Type.

Often subacute and non-acute patients move between care types (acute → subacute → non-acute) with a single hospital stay. When this occurs there will

only be one formal separation date but there can be many statistical separation dates depending on how many care type changes have occurred.

Examples

Example 1: A patient was discharged from hospital on 1st July 2017.

Separation Date	0	1	0	7	2	0	1	7

Example 2: A patient was transferred from hospital on 20th February 2017.

Separation Date	2	0	0	2	2	0	1	7

Example 3: A patient died on 23rd March 2017.

Separation Date	2	3	0	3	2	0	1	7

Validations All data quality performed on this data item is incorporated in the HMDC data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

Related Items None specified.

Administration

Purpose To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users WA Department of Health

Collection start 1 July 2012

Data available 2012-13, 2013-14, 2014-15

Definition source WA Department of Health

Ward

Specification

Definition The ward or unit within the hospital where the patient was being treated immediately prior to discharge or care type change.

METeOR reference Not applicable

Field size 20 **Layout** Character

Location HMDS Record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute/non-acute care

Reported for For each episode of admitted care where the Care Type is:

22 – Rehabilitation Care
23 – Palliative Care
24 – Psychogeriatric Care
25 – Maintenance Care
29 – Geriatric Evaluation and Management

Permissable values Free text up to 20 characters

Reporting guide A person can receive subacute and non-acute care in any hospital ward, however there are hospitals with subacute wards dedicated to the provision of subacute care. These wards are called Designated Wards.

Refer to *Appendix 1: SANADC Designated Ward Listing* for a current listing of all designated subacute wards.

Designated Subacute Wards

A designated ward is a ward that is dedicated to providing care for patients receiving a specific subacute Care Type. A ward is considered designated if the majority of subacute services that it provides under a specific subacute care type are:

- delivered under the management of or informed by a clinician with specialised expertise in a subacute care type
- evidenced by a care type change
- provided in accordance with an individualised, multidisciplinary management plan
- involves formal assessment of functional ability within 72 hours of admission
- recorded in both the medical record and applicable information register/system e.g. QoCR, webPAS Subacute Module.

A subacute service provided on a ward must comply with the above criteria in

order to be designated.

If a hospital identifies that a particular ward meets all criteria to be a Designated Ward, then they should contact the Health Reform and the SANADC to discuss qualification and reporting arrangements. Contact information can be found in Contact Details.

Non-Designated Subacute Wards

A non-designated ward is a ward that is not dedicated to providing care for patients receiving a specific subacute Care Type or the ward is dedicated only in part. Subacute patients can still been admitted in non-designated wards, however the health service must report the necessary clinical assessment data that corresponds to the care type.

If the clinical assessment data is not reported for a subacute patient admitted in a non-designated ward, then the health service should review the care type and determine whether the episode meets all the admission requirements for allocation of the subacute care type.

Non-acute Wards

There are no wards designated for the delivery of Maintenance Care – Maintenance Care can occur in any ward.

Validations All data quality performed on this data item is incorporated in the HMDC data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

Related Items None specified.

Administration

Purpose To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users WA Department of Health

Collection start 1 July 2012

Data available 2012-13, 2013-14, 2014-15

Definition source WA Department of Health

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SECTION 8: CLINICAL DATA ELEMENT DEFINITIONS

Functional Independence Measure (FIM)

Specification

Definition The Functional Independence Measure™ as assessed on admission.

METeOR reference 449150

Field size 18 Layout NNNNNNNNNNNNNNNNNN
Right justified with leading zeros.

Location Subacute Record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for For each episode of admitted care where the Care Type is:

22 – Rehabilitation Care
29 – Geriatric Evaluation and Management

Permissable values
1 – Total assistance with helper
2 – Maximal assistance with helper
3 – Moderate assistance with helper
4 – Minimal assistance with helper
5 – Supervision or setup with helper
6 – Modified independence with helper
7 – Complete independence

Reporting guide The FIM™ is a clinical assessment tool applied to patients receiving Rehabilitation or GEM care to provide a basic indicator of disability severity. The functional ability of these patients can change during the care process and therefore the FIM™ instrument is useful in measuring the level of change and effectiveness of care.

FIM™ is comprised of 18 items grouped into 2 subscales – motor and cognition.

Item sequence	Motor subscale	Item sequence	Cognitive subscale
1	Eating	14	Comprehension
2	Grooming	15	Expression
3	Bathing	16	Social interaction
4	Dressing upper body	17	Problem solving
5	Dressing lower body	18	Memory
6	Toileting		
7	Bladder management		
8	Bowel management		
9	Transfers to bed/chair/wheelchair		
10	Transfers to toilet		
11	Transfers to bath/shower		

12	Walk/wheelchair	
13	Stairs	

The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task associated with that item. The total FIM™ score ranges from 18 to 126. The total FIM™ score for the motor subscale (the sum of the individual motor subscale items) will be a value between 13 and 91. The total FIM™ score for the cognition subscale (the sum of the individual cognition subscale items) will be a value between 5 and 35.

For statistical separations from episodes with Care Type 22 or 29 to episodes with Care Type 22 or 29 the Separation FIM™ of the prior episode may be repeated as the Admission FIM™ of the subsequent episode.

The FIM™ on Admission should be completed within 72 hours of the start of the admitted episode. Timely completion of the FIM™ on admission will be assessed using the Assessment Date. Where a FIM™ on Separation is recorded, this should also be completed within 72 hours prior to the end of the admitted episode.

The FIM™ on Separation for patients who die in hospital, assign a score of 1 for each item, resulting in to total FIM™ on Separation score of 18.

FIM™ on Admission and FIM™ on Separation are not required for patients aged 17 years and under at the time of admission.

FIM Training and Credentialing

The Australian Rehabilitation Outcomes Collaboration (AROC), under the auspices of the AHSRI, holds the license for the use of the FIM™ instrument. The AROC are the national certification and training body for the FIM™ instrument. The AROC requires clinicians to be formally trained and credentialed in the application of the FIM instrument and undergo credentialing exams every two years to ensure knowledge and skills are relevant and up-to-date.

Training workshops are administered through the AHSRI. For more information on FIM™ instrument training and credentialing, please refer to the AHSRI website: http://ahsri.uow.edu.au/aroc/training/index.html#offerred.

Validations

Edit No.	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

Related Items

FIM™ must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admgroom42/index.html.

Administration

Purpose	To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.
Principal data users	WA Department of Health
Collection start	1 July 2012
Data available	2012-13, 2013-14, 2014-15
Definition source	WA Department of Health

HoNOS 65+

Specification

Definition

An assessment of the severity of a person's psychiatric symptoms, as represented by a HoNOS65+ score-based code.

METeOR reference

449363

Field size **Layout**

Location

Mental Health Record

Reported by

Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for

For each episode of admitted care where the Care Type is:

24 – Psychogeriatric Care

Permissable values

0 – No problems within the period stated
1 – Minor problem requiring no action
2 – Mild problem but definitely present
3 – Moderately severe problem
4 – Severe to very severe problem

Reporting guide

The Health of the National Outcome Scale for elderly people (HoNOS 65+) is used to rate adult mental health service users. Together, the scales rate various aspects of mental and social health.

HoNOS 65+ is answered on an item-specific anchored 4-point scale with higher scores indicating more problems. Each scale is assigned a value of between 0 and 4. The twelve scales are as follows:

- Behavioural disturbance
- Non-accidental self-injury
- Problem drinking or drug use
- Cognitive problems
- Problems related to physical illness or disability
- Problems associated with hallucinations and delusions
- Problems associated with depressive symptoms
- Other mental and behavioural problems
- Problems with social or supportive relationships
- Problems with activities of daily living
- Overall problems with living conditions
- Problems with work and leisure activities and the quality of the daytime environment

The sum of the individual scores for each of the scales represents the total HoNOS 65+ score. The total HoNOS 65+ score ranges from 0 to 48, and represents the overall severity of an individual's psychiatric symptoms.

Validations

Edit No.	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

A HoNOS 65+ must be collected at the start of a Psychogeriatric episode.

The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

Related Items

The HoNOS 65+ must be captured in accordance with NOCC data collection requirements that are administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.

Administration

Purpose

To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users

WA Department of Health

Collection start

1 July 2012 – Data prior to this is available via the Mental Health Data Collection at WA Department of Health

Data available

2012-13, 2013-14, 2014-15

Definition source

WA Department of Health

Impairment Code

Specification

Definition The primary impairment which is the reason for the admission to the sub-acute episode, as represented by a code.

METeOR reference 449141

Field size 1 **Layout** Character

Location Rehabilitation record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for For each episode of admitted care where the Care Type is:
22 – Rehabilitation Care
29 – Geriatric Evaluation and Management

Permissable values Refer to *Appendix 3: AROC Impairment Codes (Australian Version 2) (effective July 2012)*

Reporting guide The AROC impairment code set classifies the primary reason for a patient undergoing an episode of rehabilitation care.

The code set covers the following impairment categories:

- Stroke
- Brain dysfunction
- Neurological conditions
- Spinal cord dysfunction
- Amputation of limb
- Arthritis
- Pain syndromes
- Orthopaedic conditions
- Cardiac
- Pulmonary
- Burns
- Congenital deformities
- Other disabling impairments
- Major multiple trauma
- Developmental disabilities
- Re-conditioning/restorative

An Impairment Code is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes).

The Impairment Code must be collected within 72 hours of the start of a

Rehabilitation or GEM episode.

Validations

Edit No.	Edit Message	Edit Severity
2000	Impairment code is missing	Critical
2001	Impairment type is invalid	Critical

Related Items

The Impairment Code must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admgroom42/index.html.

Administration

Purpose

To facilitate the classification of subacute episodes in to AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users

WA Department of Health

Collection start

1 July 2012

Data available

2012-13, 2013-14, 2014-15

Definition source

WA Department of Health

Palliative Care Phase Start Date

Specification

Definition The date on which an admitted patient commences a phase of palliative care.

METeOR reference 445858

Field size 8 **Layout** DDMMYYYY

Location Palliative care record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for For each episode of admitted care where the Care Type is:

23 – Palliative Care

Permissable values DDMMYYYY

Reporting guide This data item identifies the time period in which the phase of care occurred and is used in the derivation of length of phase.

Within a given Palliative Care episode, there can be many phases. Phases must be reported in date sequence. SANADC will accept up to a maximum of 11 Phases of Care. Any more than 11 Phases of Care do not contribute to the AN-SNAP classification process.

The first Phase Start Date is equal to the associated Admission or Care Type Start Date. Subsequent Phase Start Dates are equal to the previous Phase End Date.

Validations

Edit No.	Edit Message	Edit Severity
5001	Phase of care is missing and/or end date	Critical
5002	Phase of care does not cover whole episode duration	Critical
5003	Phase of care end date does not correspond with next phase of care start date	Critical
5006	First phase of care start date is before admission date	Critical
5007	First phase of care start date is after admission date	Critical

Related Items Palliative Care Phase End Date; Palliative Care Phase Type; RUG-ADL

Administration

Purpose To facilitate the classification of subacute episodes into AN-SNAP groups which

	are then used to inform Activity Based Funding.
Principal data users	WA Department of Health
Collection start	1 July 2014
Data available	2014-15
Definition source	WA Department of Health

Palliative Care Phase End Date

Specification

Definition The date on which an admitted patient completes a phase of palliative care.

METeOR reference 445598

Field size 8 **Layout** DDMMYYYY

Location Palliative care record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for For each episode of admitted care where the Care Type is:

23 – Palliative Care

Permissable values DDMMYYYY

Reporting guide This data item identifies the time period in which the phase of care occurred and is used in the derivation of length of phase.

Within a given Palliative Care episode, there can be many phases. Phases must be reported in date sequence. SANADC will accept up to a maximum of 11 Phases of Care. Any more than 11 Phases of Care do not contribute to the AN-SNAP classification process.

The Palliative Care Phase End Date is equal to the next Phase Start Date. The last Palliative Care End Date is equal to the Episode or Care Type End Date.

Validations

Edit No.	Edit Message	Edit Severity
5001	Phase of care is missing and/or end date	Critical
5002	Phase of care does not cover whole episode duration	Critical
5003	Phase of care end date does not correspond with next phase of care start date	Critical
5004	Last phase of care end date is after separation date	Critical
5005	Last phase of care end date is before separation date	Critical

Related Items Palliative Care Phase Start Date; Palliative Care Phase Type; RUG-ADL

Administration

Purpose To facilitate the classification of subacute episodes into AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users	WA Department of Health
Collection start	1 July 2014
Data available	2014-15
Definition source	WA Department of Health

Palliative Care Phase Type

Specification

Definition The patient's stage of illness or situation within the episode of care in terms of the recognised phases of palliative care, as represented by a code.

METeOR reference 445942

Field size 1 **Layout** N

Location Palliative care record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for For each episode of admitted care where the Care Type is:

23 – Palliative Care

Permissable values
1 – Stable
2 – Unstable
3 – Deteriorating
4 – Terminal
9 – Unknown

Reporting guide Palliative care phases provide a clinical indication of the type of care required and have been shown to correlate strongly with survival within longitudinal prospective studies.

Within a given Palliative Care episode, there can be many phases. Phases must be reported in date sequence. SANADC will accept up to a maximum of 11 Phases of Care. Any more than 11 Phases of Care do not contribute to the AN-SNAP classification process.

A phase record should not have the same Palliative Care Phase Type as the previous or next phase record within an episode. Each time the Palliative Care Phase Type changes, a new set of the Phase of Care Start Date, Phase of Care End Date and RUG-ADL on phase change must be reported.

Valid Values

The following Value definitions have been sourced from the AHSRI Palliative Care Outcomes Collaboration Clinical Manual (2014):

1 – Stable

The patient symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned. The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

2 – Unstable

The patient experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which requires an urgent change in management or emergency treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

3 – Deteriorating

The patient experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment. The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

4 – Terminal

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak
- Essentially bed bound
- Drowsy for extended periods
- Disoriented for a time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication
- This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

9 - Unknown

The phase of the illness has not been reported.

Validations

Edit No.	Edit Message	Edit Severity
5000	Phase of care information is missing	Critical
5008	Palliative phase of care is missing	Critical
5009	Palliative phase of care is invalid	Critical

Related Items Palliative Care Phase Start Date; Palliative Care Phase End Date; RUG-ADL

Administration

Purpose To facilitate the classification of subacute episodes into AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users	WA Department of Health
Collection start	1 July 2014
Data available	2014-15
Definition source	WA Department of Health

Resource Utilisation Group – Activities of Daily Living (RUG-ADL)

Specification

Definition

The Resource Utilisation Group – Activities of Daily Living score associated with assessment of an admitted patient's ability to move in bed.

METeOR reference

495909

Field size 1 **Layout** N

Location

Palliative care record; Maintenance care record

Reported by

Public hospitals
Private hospitals that provide publicly funded subacute/non-acute care

Reported for

For each episode of admitted care where the Care Type is:

23 – Palliative Care
25 – Maintenance Care

Permissable values

For Bed mobility, Toileting and Transfers, the following values are applicable:

1 – Independent or supervision only
3 – Limited physical assistance
4 – Other than two person physical assist
5 – Two or more person physical assist

For Eating the following values are applicable:

1 – Independent or supervision only
2 – Limited assistance
3 – Extensive assistance/total dependence/tube fed

Reporting guide

The RUG-ADL is a clinical assessment tool that measures the level of functional dependence of a patient for four activities of daily living. The values assigned as part of a RUG-ADL assessment provide an indication of what a person actually does, not what they are capable of doing.

RUG-ADL measures the motor function of a patient for the following four activities of daily living:

- Bed mobility
- Toileting
- Transfers
- Eating

RUG-ADLs scores are mandatory for patients receiving admitted Palliative care and/or admitted Maintenance care. The total RUG-ADL score (the sum of the individual scale items) will be a value between 4 and 18. A person with a Total RUG-ADL score of 4 is considered independent. A person with a Total RUG-

ADL score of 18 requires the full assistance of 2 people.

For AN-SNAP grouping, the total of all four RUG-ADL sub-scores is the driver for allocation to an AN-SNAP group. As a general rule, the higher the total RUG-ADL score, the more dependent and potentially clinically complex the patient is.

For the purposes of reporting to SANADC and funding, only the first set of RUG-ADLs performed during the admission are required for reporting.

A score of 2 is not valid for RUG-ADL: Bed Mobility, Toileting and Transfers.

For Palliative Care episodes, a RUG-ADL score is required for each time a patient changes Phase of Care Type. Within a given Palliative Care episode, a patient can have up to 11 Phases of Care. Where more than 11 Phases of Care occur, all RUG-ADL scores captured after the 11th change are omitted and only the details on the final (i.e. the 11th) RUG-ADL is reported.

Valid Values

The following Value definitions have been sourced from the AHSRI Palliative Care Outcomes Collaboration Clinical Manual (2014):

Bed Mobility

Refers to the patient's ability to move in bed after the transfer into bed has been completed. Choose a score from:

1 – Independent or supervision only

Patient is able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. The patient does not require assistance and they may be independent with the use of a device.

3 – Limited physical assistance

Patient is able to readjust position in bed, and perform own pressure area relief, with the assistance of one person.

4 – Other than two persons physical assist

Patient requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. The patient still requires the assistance of one person for task.

5 – Two or more persons physical assist

Patient requires two or more assistants to readjust patient's position in bed, and perform pressure area relief.

Toileting

Refers to the patient's ability to mobilise to the toilet, adjust clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If the level of assistance differs between voiding and bowel movement record the lower performance. Choose a score from:

1 – Independent or supervision only

Patient is able to mobilise to toilet, adjust clothing, cleanse self and has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance is required. May be independent with the use of a device.

3 – Limited physical assistance

Patient requires hands-on assistance of one person for one or more of the tasks**.**

4 – Other than two persons physical assist

Patient requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/suppository. Requires assistance of one person for management of the device

5 – Two or more persons physical assist

Patient requires two or more assistants to perform any step of the task.

Transfers

Refers to the patient's ability to transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night. Choose a score from:

1 – Independent or supervision only

Patient is able to perform all transfers independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.

3 – Limited physical assistance

Patient requires hands-on assistance of one person to perform any transfer of the day/night.

4 – Other than two persons physical assist

Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.

5 – Two or more persons physical assist

Requires two or more assistants to perform any transfer of the day/night.

Eating

Refers to the patient's ability to cut food, bring food to mouth and chew and swallow food. Does not include preparation of the meal. Choose a score from:

1 – Independent or supervision only

Patient is able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. Patient does not require hands-on assistance.

This score should be used where a patient who relies on parenteral or gastrostomy feeding is able to self-administer.

2 – Limited assistance

Patient requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).

3 – Extensive assistance/total dependence/tube fed

Patient needs to be fed their meal by assistant, or does not eat or drink full meals by mouth.

This score should be used where a patient who relies on parenteral or gastrostomy feeding is unable to self-administer.

Validations

Edit No.	Edit Message	Edit Severity
4000	RUG-ADL assessment is missing for maintenance episode	Critical
4001	RUG-ADL assessment score(s) is not complete	Critical
4002	RUG-ADL assessment score(s) is not in range for maintenance episode	Critical
5012	RUG-ADL assessment score(s) missing for palliative phase	Critical
5013	RUG-ADL assessment score(s) is not in range for palliative phase	Critical

Related Items

Palliative Care Phase Start Date; Palliative Care Phase End Date; Palliative Care Phase Type; Type of Maintenance

Administration

Purpose

To facilitate the classification of subacute and non-acute episodes into AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users	WA Department of Health
Collection start	Collection has not commenced
Data available	Nil
Definition source	WA Department of Health

Standardised Mini-Mental State Examination (SMMSE)

Specification

Definition The person's degree of cognitive ability to process thoughts and respond appropriately and safely, as represented by a Standardised Mini-Mental State Examination (SMMSE) score-based code.

METeOR reference 617812

Field size 1 **Layout** N

Location Geriatric Evaluation and Management (GEM) record

Reported by Public hospitals
Private hospitals that provide publicly funded subacute care

Reported for For each episode of admitted care where the Care Type is:

29 – Geriatric Evaluation and Management

Permissable values
0 – Score of 0
1 – Score of 1
2 – Score of 2
3 – Score of 3
4 – Score of 4
5 – Score of 5

Reporting guide The Standardised Mini-Mental State Examination (SMMSE) designed to screen and measure cognitive impairment.

The SMMSE consists of 12 items or questions which assess a range of cognitive domains, requiring vocal and physical actions (such as memory recall and drawing) in response to reading and listening to commands. Each item has a maximum score:

Question No.	Cognitive Domain	Maximum Score
1.	Orientation – time	5
2.	Orientation – place	5
3.	Memory – immediate	3
4.	Language/attention	5
5.	Memory – short	3
6.	Language/memory – long	1
7.	Language/memory – long	1
8.	Language/abstract thinking/verbal fluency	1
9.	Language	1
10.	Language/attention/comprehension	1
11.	Attention/comprehension/follow commands/constructional	1
12.	Attention/comprehension/construction/follow	3

	commands	
	Total Score	30

Please note that there are two questions relating to the Cognitive Domain for Language/memory – Long.

Scoring guidelines

- Scores above 1 are not permissible for questions 6 – 11.
- Scores above 3 are not permissible for questions 3 and 12.
- Scores above 5 are not permissible for items 1, 2 and 4.
- The final SMMSE score is a sum of the scores for the 12 Cognitive Domains and can range from a minimum of 0 to a maximum of 30. The SMMSE can be adjusted for non-cognitive disabilities.
- As outlined in the SMMSE guidelines, if an item cannot be modified or adjusted then the item is omitted, reducing the maximum obtainable score from 30. The formula (Actual score x 30) / Maximum obtainable score) is used to readjust the score to be comparable with unadjusted scores.

Business rules for data collection

The following are some key business rules that need to be observed when collecting SMMSE data and are applicable to all reporting Health Services:

- SMMSE scores are only required to be reported if an SMMSE has actually been performed during the GEM episode of care. It is understood that not all GEM episodes of care will have a SMMSE performed.
- A SMMSE is only required for collection and reporting where the care type is GEM.
- Only one array of SMMSE scores (i.e. 12 individual scores) per GEM episode are required to be reported.
- If multiple sets of SMMSE scores are recorded in the patient's record, the set of scores (i.e. 12 individual scores) which demonstrate the lowest level of cognitive ability recorded during the GEM episode should be reported.

SMMSE Resources

On behalf of the Commonwealth, the Independent Hospital Pricing Authority (IHPA) has purchased the Australian intellectual property rights of the SMMSE. IHPA has granted permission for all health care facilities and aged care services throughout Australia to freely use the SMMSE. As such, it is not required to seek approval from IHPA to use the SMMSE tool in Australia. The SMMSE consists of the Guidelines for Administration and Scoring Instructions booklet (this booklet), and a separate SMMSE tool. The Guidelines for Administration and Scoring Instructions booklet offers comprehensive instructions that accompany the SMMSE tool, and both materials should always be used in conjunction. The SMMSE materials are available for download on IHPA's website via the following subacute care link:
www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/subacute-care

Validations

There are currently no validations in place to assess the quality of the SMMSE as provision of SMMSE scores is not mandatory.

Related Items	Palliative Care Phase Start Date; Palliative Care Phase End Date; Palliative Care Phase Type; Type of Maintenance

Administration

Purpose	To enable capture and analysis of cognitive assessment data that may be utilised for future AN-SNAP classification and funding mechanisms.
Principal data users	WA Department of Health
Collection start	1 July 2015
Data available	2015/2016
Definition source	WA Department of Health

Type of Maintenance Care

Specification

Definition The nature of the maintenance care provided to an admitted patient during an episode of care, as represented by a code.

METeOR reference 496467

Field size 1 **Layout** N

Location Maintenance record

Reported by Public hospitals

Reported for For each episode of admitted care where the Care Type is:

25 – Maintenance Care

Permissable values
1 – Convalescent
2 – Respite
3 – Nursing home type
5 – Other
8 – Unknown

Reporting guide This data element is required to be recorded for all maintenance care type episodes.

The Type of Maintenance Care should be recorded at the start of the admitted episode.

Valid Values

1 – Convalescent

Following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include:

- patients awaiting the completion of home modifications essential for discharge
- patients awaiting the provision of specialised equipment essential for discharge
- patients awaiting rehousing
- patients awaiting supported accommodation such as hostel or group home bed
- patients for whom community services are essential for discharge but are

not yet available.

2 – Respite

An episode where the primary reason for admission is the short-term unavailability of the patient's usual care. Examples may include:

- admission due to carer illness or fatigue
- planned respite due to carer unavailability
- short term closure of care facility
- short term unavailability of community services.

3 – Nursing home type

The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

5 – Other

Any other reason the patient may require a maintenance episode other than those already stated.

8 – Unknown

It is not known what type of maintenance care the patient is receiving.

Validations

Edit No.	Edit Message	Edit Severity
6000	Type of maintenance care is missing	Critical
6001	Type of maintenance care is invalid	Critical

Related Items

Administration

Purpose To facilitate the classification of non-acute episodes into AN-SNAP groups which are then used to inform Activity Based Funding.

Principal data users WA Department of Health

Collection start Collection has not commenced

Data available Nil

Definition source WA Department of Health

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SECTION 9: CLASSIFICATION OF SUBACUTE & NON-ACUTE ACTIVITY

9.1 AN-SNAP

9.1.1 What is the AN-SNAP Classification?

The AN-SNAP Classification is a list of classes that are used to categorise 'like' subacute and non-acute patient care episodes together based predominantly on the functional and cognitive ability of the patient. Classifying the activity into meaningful groups, makes it easier to consistently and fairly calculate the cost of delivering patient care.

The AN-SNAP Classification can be applied to subacute and non-acute activity in the admitted, non-admitted and community settings.

The Care Types in scope for AN-SNAP classification are restricted to Rehabilitation, GEM, Psychogeriatric, Palliative Care and Maintenance Care only.

9.1.2 What is the difference between AN-SNAP and AR-DRG Classification?

The Australian Refined –Diagnosis Related Groups (AR-DRGs) and the AN-SNAP classification are similar in that they are lengthy lists of clinically meaningful classes that are used to group 'like' episodes together. However, the difference between them lies in the type of information that needs to be recorded in order to group 'like' episodes together. To classify an episode under the AR-DRG classification, the diagnoses and procedures codes assigned during the post-discharge clinical coding process are pivotal. In contrast, to classify an episode under AN-SNAP, the diagnosis and procedures codes are largely irrelevant and instead the clinical assessment scores captured on admission are the key determinant in the classification process.

Historically, AR-DRGs have been the nominated classification for funding subacute and non-acute activity. While subacute and non-acute activity will always be clinical coded and classified under the AR-DRG classification, the IHPA has determined that it will exclusively fund subacute and non-acute activity using the AN-SNAP classification. This is because AN-SNAP has proven to be more sensitive to the clinical variances and complexities between patients with similar or even the same diagnoses and therefore potentially more precise in the calculation of the true cost for delivering patient care.

9.1.3 Versions of AN-SNAP

From 1 July 2016, the AN-SNAP Version 4 classification will be applied to all subacute and non-acute moving forward. Although very different in structure to AN-SNAP Version 3, Version 4 has expanded on many of the gaps within Version 3 to include classes for paediatrics.

The following table outlines the classification in use for subacute and non-acute activity data across the reporting periods:

Version	Period of application
AN-SNAP Version 3	1 July 2012 – 30 June 2016
AN-SNAP Version 4	From 1 July 2016

Please refer to *Appendix 2: AN-SNAP Classification Version 4* for a listing of the current AN-SNAP classification.

SECTION 10: APPENDICES

Appendix 1: SANADC Designated Ward Listing

The following tables provide listings of the ward designated to provide subacute services. Please note that an asterisk next to the Ward indicates that is more than one type of subacute service is provided in that Ward.

Designated Rehabilitation Care Wards (current at 1 July 2016)

Establishment Code	Establishment Name	Ward(s)
0201	Albany Hospital	SUBAC – Ward E
0203	Armadale Kelmscott District Memorial Hospital	REHAB
0255	Bentley Hospital	W4* W5*
0208	Bunbury Hospital	SARU
0106	Fiona Stanley Hospital	SRSB SRS1A SRS2A
0102	Fremantle Hospital and Health Service	V5 V6
0220	Geraldton Hospital	To be advised
0642	Joondalup Health Campus	JHCWD0 JHCLD0 JHCBD0 JHCWL0 JHCWC1B JHCWL1 JHCWC1A JHCWA1
0454	Kalamunda District Community Hospital	ANDT**
0226	Kalgoorlie Hospital	Any ward
0239	Osborne Park Hospital	Ward 3* Ward 4* Ward 5* Ward 6* (overflow)
0645	Peel Health Campus	RESTORATIVE
0277	Rockingham General Hospital	ACRU*
0101	Royal Perth Hospital	9A*
6007	St John of God – Midland	1A*
0629	St John of God – Mt Lawley	MRU

Establishment Code	Establishment Name	Ward(s)
0244	Swan District Hospital	REST

Designated GEM Care Wards (current at 1 Jan 2016)

Establishment Code	Establishment Name	Ward(s)
0201	Albany Hospital	SUBAC – Ward E*
0203	Armadale Kelmscott District Memorial Hospital	REHAB
0255	Bentley Hospital	W4*
0102	Fremantle Hospital and Health Service	GEM V6
0239	Osborne Park Hospital	Ward 3* Ward 4* Ward 5* Ward 6* (overflow)
0277	Rockingham General Hospital	ACRU*
0101	Royal Perth Hospital	9A*
0105	Sir Charles Gairdner Hospital	C17
6007	St John of God – Midland	1A*

Designated Psychogeriatric Care Wards (current at 1 July 2016)

Establishment Code	Establishment Name	Ward(s)
0203	Armadale Kelmscott District Memorial Hospital	BANKS
0255	Bentley Hospital	W10A W10B W10C
0102	Fremantle Hospital and Health Service	W43
0239	Osborne Park Hospital	OL (Osborne Lodge)
0277	Rockingham General Hospital	MHEC MHEO
0158	Selby Lodge	PICU SELB
0629	St John of God – Mt Lawley	UFU (Ursula Frayne Unit)
0244	Swan District Hospital	MHE (inactive 4/11/15) MHW (inactive 4/11/15)

Designated Palliative Care Wards (current at 1 July 2016)

Establishment Code	Establishment Name	Ward(s)
602	Bethesda Hospital	BAY
454	Kalamunda District Community Hospital	ANDT**
612	St John of God – Bunbury	GRA
640	St John of God – Murdoch	HOS

Please note that as ePaLCIS is implemented across specialist palliative care services and reporting of palliative care activity expands, the term 'designated' may lose applicability as it will be possible to have a palliative Care Type in any ward.

*Combined Rehabilitation and GEM Care ward
**Combined Rehabilitation and Palliative Care Ward

Appendix 2: AN-SNAP Classification Version 4

The following section provides a descriptive listing of the Australian National Subacute and Non-acute Patient classification (Version 4).

Class	Episode Type	Description
Class	**Episode Type**	**Description**
4AZ1	Admitted Adult Rehabilitation	Weighted FIM motor score 13-18, Brain, Spine, MMT, Age ≥ 49
4AZ2	Admitted Adult Rehabilitation	Weighted FIM motor score 13-18, Brain, Spine, MMT, Age ≤ 48
4AZ3	Admitted Adult Rehabilitation	Weighted FIM motor score 13-18, All other impairments, Age ≥ 65
4AZ4	Admitted Adult Rehabilitation	Weighted FIM motor score 13-18, All other impairments, Age ≤ 64
4AA1	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 51-91, FIM cognition 29-35
4AA2	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 51-91, FIM cognition 19-28
4AA3	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 51-91, FIM cognition 5-18
4AA4	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 36-50, Age ≥ 68
4AA5	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 36-50, Age ≤ 67
4AA6	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 19-35, Age ≥ 68
4AA7	Admitted Adult Rehabilitation	Stroke, weighted FIM motor 19-35, Age ≤ 67
4AB1	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 71-91, FIM cognition 26-35
4AB2	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 71-91, FIM cognition 5-25
4AB3	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 41-70, FIM cognition 26-35
4AB4	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 41-70, FIM cognition 17-25
4AB5	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 41-70, FIM cognition 5-16
4AB6	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 29-40
4AB7	Admitted Adult Rehabilitation	Brain dysfunction, weighted FIM motor 19-28
4AC1	Admitted Adult Rehabilitation	Neurological conditions, weighted FIM motor 62-91
4AC2	Admitted Adult Rehabilitation	Neurological conditions, weighted FIM motor 43-61
4AC3	Admitted Adult Rehabilitation	Neurological conditions, weighted FIM motor 19-42
4AD1	Admitted Adult Rehabilitation	Spinal cord dysfunction, Age ≥ 50, weighted FIM motor 42-91
4AD2	Admitted Adult Rehabilitation	Spinal cord dysfunction, Age ≥ 50, weighted FIM motor 19-41
4AD3	Admitted Adult Rehabilitation	Spinal cord dysfunction, Age ≤ 49, weighted FIM motor 34-91
4AD4	Admitted Adult Rehabilitation	Spinal cord dysfunction, Age ≤ 49, weighted FIM motor 19-33
4AE1	Admitted Adult Rehabilitation	Amputation of limb, Age ≥ 54, weighted FIM motor 68-91
4AE2	Admitted Adult Rehabilitation	Amputation of limb, Age ≥ 54, weighted FIM motor 31-67

Class	Episode Type	Description
4AE3	Admitted Adult Rehabilitation	Amputation of limb, Age ≥ 54, weighted FIM motor 19-30
4AE4	Admitted Adult Rehabilitation	Amputation of limb, Age ≤ 53, weighted FIM motor 19-91
4AH1	Admitted Adult Rehabilitation	Orthopaedic conditions, fractures, weighted FIM motor 49-91, FIM cognition 33-35
4AH2	Admitted Adult Rehabilitation	Orthopaedic conditions, fractures, weighted FIM motor 49-91, FIM cognition 5-32
4AH3	Admitted Adult Rehabilitation	Orthopaedic conditions, fractures, weighted FIM motor 38-48
4AH4	Admitted Adult Rehabilitation	Orthopaedic conditions, fractures, weighted FIM motor 19-37
4A21	Admitted Adult Rehabilitation	Orthopaedic conditions, all other (including replacements), weighted FIM motor 68-91
4A22	Admitted Adult Rehabilitation	Orthopaedic conditions, all other (including replacements), weighted FIM motor 50-67
4A23	Admitted Adult Rehabilitation	Orthopaedic conditions, all other (including replacements), weighted FIM motor 19-49
4A31	Admitted Adult Rehabilitation	Cardiac, Pain syndromes, Pulmonary, weighted FIM motor 72-91
4A32	Admitted Adult Rehabilitation	Cardiac, Pain syndromes, Pulmonary, weighted FIM motor 55-71
4A33	Admitted Adult Rehabilitation	Cardiac, Pain syndromes, Pulmonary, weighted FIM motor 34-54
4A34	Admitted Adult Rehabilitation	Cardiac, Pain syndromes, Pulmonary, weighted FIM motor 19-33
4AP1	Admitted Adult Rehabilitation	Major Multiple Trauma, weighted FIM motor 19-91
4AR1	Admitted Adult Rehabilitation	Reconditioning, weighted FIM motor 67-91
4AR2	Admitted Adult Rehabilitation	Reconditioning, weighted FIM motor 50-66, FIM cognition 26-35
4AR3	Admitted Adult Rehabilitation	Reconditioning, weighted FIM motor 50-66, FIM cognition 5-25
4AR4	Admitted Adult Rehabilitation	Reconditioning, weighted FIM motor 34-49, FIM cognition 31-35
4AR5	Admitted Adult Rehabilitation	Reconditioning, weighted FIM motor 34-49, FIM cognition 5-30
4AR6	Admitted Adult Rehabilitation	Reconditioning, weighted FIM motor 19-33
4A91	Admitted Adult Rehabilitation	All other impairments, weighted FIM motor 55-91
4A92	Admitted Adult Rehabilitation	All other impairments, weighted FIM motor 33-54
4A93	Admitted Adult Rehabilitation	All other impairments, weighted FIM motor 19-32
4J01	Admitted Adult Rehabilitation	Adult Same-Day Rehabilitation
499A	Admitted Adult Rehabilitation	Adult Overnight Rehabilitation - Ungroupable
4F01	Admitted Paediatric Rehabilitation	Rehabilitation, Age ≤ 3
4F02	Admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, Spinal cord dysfunction
4F03	Admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, Brain dysfunction
4F04	Admitted Paediatric	Rehabilitation, Age ≥ 4, Neurological conditions

Class	Episode Type	Description
	Rehabilitation	
4F05	Admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, All other impairments
4O01	Admitted Paediatric Rehabilitation	Paediatric Same-Day Rehabilitation
499F	Admitted Paediatric Rehabilitation	Paediatric Overnight Rehabilitation - Ungroupable
4BS1	Admitted Adult Palliative Care	Stable phase, RUG-ADL 4-5
4BS2	Admitted Adult Palliative Care	Stable phase, RUG-ADL 6-16
4BS3	Admitted Adult Palliative Care	Stable phase, RUG-ADL 17-18
4BU1	Admitted Adult Palliative Care	Unstable phase, First Phase in Episode, RUG-ADL 4-13
4BU2	Admitted Adult Palliative Care	Unstable phase, First Phase in Episode, RUG-ADL 14-18
4BU3	Admitted Adult Palliative Care	Unstable phase, Not first Phase in Episode, RUG-ADL 4-5
4BU4	Admitted Adult Palliative Care	Unstable phase, Not first Phase in Episode, RUG-ADL 6-18
4BD1	Admitted Adult Palliative Care	Deteriorating phase, RUG-ADL 4-14
4BD2	Admitted Adult Palliative Care	Deteriorating phase, RUG-ADL 15-18, Age ≥ 75
4BD3	Admitted Adult Palliative Care	Deteriorating phase, RUG-ADL 15-18, Age 55-74
4BD4	Admitted Adult Palliative Care	Deteriorating phase, RUG-ADL 15-18, Age ≤ 54
4BT1	Admitted Adult Palliative Care	Terminal phase
4K01	Admitted Adult Palliative Care	Adult Same-Day Palliative Care
499B	Admitted Adult Palliative Care	Adult Overnight Palliative Care - Ungroupable
4G01	Admitted Paediatric Palliative Care	Palliative Care, Not Terminal phase, Age < 1 year
4G02	Admitted Paediatric Palliative Care	Palliative Care, Stable phase, Age ≥ 1 year
4G03	Admitted Paediatric Palliative Care	Palliative Care, Unstable or Deteriorating phase, Age ≥ 1 year
4G04	Admitted Paediatric Palliative Care	Palliative Care, Terminal phase
4P01	Admitted Paediatric Palliative Care	Paediatric Same-Day Palliative Care
499G	Admitted Paediatric Palliative Care	Overnight Paediatric Palliative Care - Ungroupable
4CH1	Admitted GEM	FIM motor 57-91 with Delirium or Dementia
4CH2	Admitted GEM	FIM motor 57-91 without Delirium or Dementia
4CM1	Admitted GEM	FIM motor 18-56 with Delirium or Dementia
4CM2	Admitted GEM	FIM motor 18-56 without Delirium or Dementia
4CL1	Admitted GEM	FIM motor 13-17 with Delirium or Dementia
4CL2	Admitted GEM	FIM motor 13-17 without Delirium or Dementia
4L01	Admitted GEM	Same-Day GEM
499C	Admitted GEM	Overnight GEM - Ungroupable
4DS1	Admitted Psychogeriatric	HoNOS 65+ Overactive behaviour 3-4, LOS ≤ 91

Class	Episode Type	Description
4DS2	Admitted Psychogeriatric	HoNOS 65+ Overactive behaviour 1-2, HoNOS 65+ ADL 4, LOS ≤ 91
4DS3	Admitted Psychogeriatric	HoNOS 65+ Overactive behaviour 1-2, HoNOS 65+ ADL 0-3, LOS ≤ 91
4DS4	Admitted Psychogeriatric	HoNOS 65+ Overactive behaviour 0, HoNOS 65+ total 18-48, LOS ≤ 91
4DS5	Admitted Psychogeriatric	HoNOS 65+ Overactive behaviour 0, HoNOS 65+ total 0-17, LOS ≤ 91
4DL1	Admitted Psychogeriatric	Long term care
4M01	Admitted Psychogeriatric	Same-Day Psychogeriatric Care
499D	Admitted Psychogeriatric	Overnight Psychogeriatric Care - Ungroupable
4ES1	Admitted Non-Acute	Age ≥ 60, RUG-ADL 4-11, LOS ≤ 91
4ES2	Admitted Non-Acute	Age ≥ 60, RUG-ADL 12-15, LOS ≤ 91
4ES3	Admitted Non-Acute	Age ≥ 60, RUG-ADL 16-18, LOS ≤ 91
4ES4	Admitted Non-Acute	Age 18-59, LOS ≤ 91
4ES5	Admitted Non-Acute	Age ≤ 17, LOS ≤ 91
4EL1	Admitted Non-Acute	Long term care
499E	Admitted Non-Acute	Admitted Non-acute Care - Ungroupable
4SY1	Non-admitted Adult Rehabilitation	Assessment only
4SA1	Non-admitted Adult Rehabilitation	Stroke program
4SB1	Non-admitted Adult Rehabilitation	Brain Dysfunction program
4SD1	Non-admitted Adult Rehabilitation	Spinal Cord Dysfunction program
4SG1	Non-admitted Adult Rehabilitation	Pain syndromes program
4S11	Non-admitted Adult Rehabilitation	Orthopaedic conditions program
4SK1	Non-admitted Adult Rehabilitation	Cardiac program
4S91	Non-admitted Adult Rehabilitation	Other program
499S	Non-admitted Adult Rehabilitation	Adult Non-admitted Rehabilitation - Ungroupable
4X01	Non-admitted Paediatric Rehabilitation	Rehabilitation, Age ≤ 3
4X02	Non-admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, Spinal cord dysfunction
4X03	Non-admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, Brain dysfunction
4X04	Non-admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, Neurological conditions
4X05	Non-admitted Paediatric Rehabilitation	Rehabilitation, Age ≥ 4, All other impairments
499X	Non-admitted Paediatric	Paediatric Non-admitted Rehabilitation - Ungroupable

Class	Episode Type	Description
	Rehabilitation	
4TS1	Non-admitted Adult Palliative Care	Stable phase
4TU1	Non-admitted Adult Palliative Care	Unstable phase, RUG-ADL 4, PCPSS 0-7
4TU2	Non-admitted Adult Palliative Care	Unstable phase, RUG-ADL 4, PCPSS 8-12
4TU3	Non-admitted Adult Palliative Care	Unstable phase, RUG-ADL 5-18
4TD1	Non-admitted Adult Palliative Care	Deteriorating phase, PCPSS 0-6
4TD2	Non-admitted Adult Palliative Care	Deteriorating phase, PCPSS 7-12, RUG-ADL 4-10
4TD3	Non-admitted Adult Palliative Care	Deteriorating phase, PCPSS 7-12, RUG-ADL 11-18
4TT1	Non-admitted Adult Palliative Care	Terminal phase
499T	Non-admitted Adult Palliative Care	Adult Non-admitted Palliative Care - Ungroupable
4Y01	Non-admitted Paediatric Palliative Care	Palliative Care, Not Terminal phase, Age < 1 year
4Y02	Non-admitted Paediatric Palliative Care	Palliative Care, Stable phase, Age ≥ 1 year
4Y03	Non-admitted Paediatric Palliative Care	Palliative Care, Unstable or Deteriorating phase, Age ≥ 1 year
4Y04	Non-admitted Paediatric Palliative Care	Palliative Care, Terminal phase
499Y	Non-admitted Paediatric Palliative Care	Paediatric Non-admitted Palliative Care - Ungroupable
4UC1	Non-admitted GEM	Single day of care without ongoing care plan
4UC2	Non-admitted GEM	Falls clinic
4UC3	Non-admitted GEM	Memory clinic
4UC4	Non-admitted GEM	Other clinic
499U	Non-admitted GEM	Non-admitted GEM - Ungroupable
4VY1	Non-admitted Psychogeriatric	Assessment only
4VA1	Non-admitted Psychogeriatric	Treatment, Focus of Care acute
4VN1	Non-admitted Psychogeriatric	Treatment, Focus of Care not acute, HoNOS 65+ total 0-8
4VN2	Non-admitted Psychogeriatric	Treatment, Focus of Care not acute, HoNOS 65+ total 9-13
4VN3	Non-admitted Psychogeriatric	Treatment, Focus of Care not acute, HoNOS 65+ total 14-48, HoNOS 65+ Overactive behaviour 0-1
4VN4	Non-admitted Psychogeriatric	Treatment, Focus of Care not acute, HoNOS 65+ total 14-48, HoNOS 65+ Overactive behaviour 2-4
499V	Non-admitted Psychogeriatric	Non-admitted Psychogeriatric Care - Ungroupable

Appendix 3: AROC Impairment Codes (Australian Version 2, effective July 2012)

The Australasian Rehabilitation Outcomes Centre (AROC) is a national body that collects and reports data on the specialist medical rehabilitation sector. Data collected for AROC is primarily used to develop a national benchmarking system to improve clinical rehabilitation outcomes, produce information on the efficacy of interventions and develop clinical and management information based on functional outcomes and impairment groupings.

The AROC Impairment Codes (as specified below) provide the list of acceptable values for capture of the subacute data element known as Impairment Type.

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
STROKE	
Stroke - haemorrhagic	
1.11	Left Body Involvement (Right Brain)
1.12	Right Body Involvement (Left Brain)
1.13	Bilateral Involvement
1.14	No Paresis
1.19	Other stroke
Stroke - ischaemic	
1.21	Left Body Involvement (Right Brain)
1.22	Right Body Involvement (Left Brain)
1.23	Bilateral Involvement
1.24	No Paresis
1.29	Other stroke
BRAIN DYSFUNCTION	
Non-traumatic brain dysfunction	
2.11	Non traumatic subarachnoid haemorrhage
2.12	Anoxic brain damage
2.13	Other non-traumatic brain dysfunction
Traumatic brain dysfunction	
2.21	Traumatic, open injury
2.22	Traumatic, closed injury
NEUROLOGICAL CONDITIONS	
3.1	Multiple sclerosis
3.2	Parkinsonism
3.3	Polyneuropathy
3.4	Guillain-Barre
3.5	Cerebral palsy
3.8	Neuromuscular disorders
3.9	Other neurologic
SPINAL CORD DYSFUNCTION	
Non-traumatic spinal cord dysfunction	

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
4.111	Paraplegia, incomplete
4.112	Paraplegia, complete
4.1211	Quadriplegia incomplete C1-4
4.1212	Quadriplegia incomplete C5-8
4.1221	Quadriplegia complete C1-4
4.1222	Quadriplegia complete C5-8
4.13	Other non-traumatic spinal cord dysfunction
Traumatic spinal cord dysfunction	
4.211	Paraplegia, incomplete
4.212	Paraplegia, complete
4.2211	Quadriplegia incomplete C1-4
4.2212	Quadriplegia incomplete C5-8
4.2221	Quadriplegia complete C1-4
4.2222	Quadriplegia complete C5-8
4.23	Other traumatic spinal cord dysfunction
AMPUTATION OF LIMB	
Amputation of limb NOT resulting from a trauma	
5.11	Single upper amputation above the elbow
5.12	Single upper amputation below the elbow
5.13	Single lower amputation above the knee
5.14	Single lower amputation below the knee
5.15	Double lower amputation above the knee
5.16	Double lower amputation above/below the knee
5.17	Double lower amputation below the knee
5.18	Partial foot amputation (includes single/double)
5.19	Other amputation
Amputation of limb as a result of trauma	
5.21	Single upper amputation above the elbow
5.22	Single upper amputation below the elbow
5.23	Single lower amputation above the knee
5.24	Single lower amputation below the knee
5.25	Double lower amputation above the knee
5.26	Double lower amputation above/below the knee
5.27	Double lower amputation below the knee
5.28	Partial foot amputation (includes single/double)
5.29	Other amputation
ARTHRITIS	
6.1	Rheumatoid arthritis
6.2	Osteoarthritis
6.9	Other arthritis
PAIN SYNDROMES	
7.1	Neck pain

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
7.2	Back pain
7.3	Extremity pain
7.4	Headache (includes migraine)
7.5	Multi-site pain
7.9	Other pain
ORTHOPAEDIC CONDITIONS	
Fracture	
8.111	Fracture of hip, unilateral (includes #NOF)
8.112	Fracture of hip, bilateral (includes #NOF)
8.12	Fracture of shaft of femur (excludes femur involving knee joint)
8.13	Fracture of pelvis
8.141	Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
8.142	Fracture of leg, ankle, foot
8.15	Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
8.16	Fracture of spine (excludes where the major disorder is pain)
8.17	Fracture of multiple sites
8.19	Other orthopaedic fracture
Post orthopaedic surgery	
8.211	Unilateral hip replacement
8.212	Bilateral hip replacement
8.221	Unilateral knee replacement
8.222	Bilateral knee replacement
8.231	Knee and hip replacement same side
8.232	Knee and hip replacement different sides
8.24	Shoulder replacement or repair
8.25	Post spinal surgery
8.26	Other orthopaedic surgery
Soft tissue injury	
8.3	Soft tissue injury
CARDIAC	
9.1	Following recent onset of new cardiac impairment
9.2	Chronic cardiac insufficiency
9.3	Heart or heart/lung transplant
PULMONARY	
10.1	Chronic obstructive pulmonary disease
10.2	Lung transplant
10.9	Other pulmonary
BURNS	
11	Burns
CONGENITAL DEFORMITIES	
12.1	Spina bifida

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
12.9	Other congenital
OTHER DISABLING IMPAIRMENTS	
13.1	Lymphoedema
13.3	Conversion disorder
13.9	Other disabling impairments. This classification should rarely be used.
MAJOR MULTIPLE TRAUMA	
14.1	Brain + spinal cord injury
14.2	Brain + multiple fracture/amputation
14.3	Spinal cord + multiple fracture/amputation
14.9	Other multiple trauma
DEVELOPMENTAL DISABILITIES	
15.1	Developmental disabilities
RE-CONDITIONING/RESTORATIVE	
16.1	Re-conditioning following surgery
16.2	Re-conditioning following medical illness
16.3	Cancer rehabilitation

Appendix 4: SANADC Data Quality Edits

The following section provides a descriptive listing of the SANADC Data Quality Edits that are currently active. The following table provides definitions on how to interpret edit documentation:

Edit Number	*A unique number assigned to each edit. The edits are classified into series based on the specific subacute measure or data item:* *1XXX FIM* *2XXX Impairment Type* *3XXX HoNOS 65+* *4XXX RUG-ADL* *5XXX Phase of Care* *6XXX Maintenance* *9XXX Other* *The Edit Number will appear on the Data Quality Error Report.*
Edit Name	*The name of the edit. This will appear on the Data Quality Error Report.*
Effect	*The edit effect indicates the impact and severity of an error on reporting and subsequent funding of an episode. It also guides data collectors on how they should handle and prioritise their edit correction to ensure maximum reporting and funding. There are two types of effect:* *Critical:* *Record is in error and cannot reported and funded as long as the error exists. Records in critical error must be corrected and resubmitted to SANADC.* *Warning:* *Record is in error or there has been some information provided that is unusual or inconsistent with other data items. The record can be reported and funded in its current state, however there may be some information within the record that is unusual or inconsistent. To address, users should work through the edit logic and check all applicable fields and correct any errors or verify the reported information as true and correct.*
Care Type(s)	*The care types that are applicable to this edit.*
Description	*A brief description of why the edit has triggered.*
Logic	*This specifies the working logic for how the edit is triggered. It is useful in highlighting the applicable data items that should be checked when correcting an edit.*

Edit Number	1000
Edit Name	FIM assessment is missing
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The subacute episode is missing the FIM Assessment Date and all FIM Assessment Scores.
Logic	IF Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 1000

Edit Number	1001
Edit Name	FIM assessment is not complete
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The subacute episode is missing one or more FIM assessment scores.
Logic	IF at least one FIM Assessment Score(s) (Data Items 9 – 26) is blank. AND Admission for Assessment Only ≠ 1 AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1001

Edit Number	1002
Edit Name	FIM assessment date is missing
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The subacute episode is missing the FIM Assessment Date however FIM Assessment Scores and/or Impairment Code information has been recorded.
Logic	IF Assessment Date (Data Item 6) is blank AND Admission for Assessment Only ≠ 1 AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1002

Edit Number	1003
Edit Name	FIM assessment date is prior to admission date
Effect	Critical

Care Type(s)	Rehabilitation; GEM
Description	The FIM Assessment Date recorded is prior to the Admission Date.
Logic	IF FIM Assessment Date (Data Item 6) < Admission Date (Data Item 3) AND Assessment Date (Data Item 6) is not blank AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1003

Edit Number	1004
Edit Name	FIM assessment date is after separation date
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The FIM Assessment Date recorded is after the Separation Date.
Logic	IF FIM Assessment Date (Data Item 6) > Separation Date (Data Item 4) AND Assessment Date (Data Item 6) is not blank AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1004

Edit Number	1005
Edit Name	FIM assessment is not within 72 hours of the start of the episode of care
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The FIM Assessment Date recorded is at least 72 hours after the Admission Date. Please correct or verify that FIM Assessment Date has been reported accurately.
Logic	IF FIM Assessment Date (Data Item 6) > 72 hours after the Admission Date (Data Item 3) AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1005

Edit Number	1006
Edit Name	FIM assessment score(s) is not in range
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	One or more of the FIM Assessment Scores recorded is not a valid score.

	Refer to the relevant Data Definition for permitted values.
Logic	IF FIM Assessment Score(s) (Data Item 9 – 26) ≠ 1, 2, 3, 4, 5, 6 or 7 AND Admission for Assessment Only ≠ 1 AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1006

Edit Number	2000
Edit Name	Impairment Type is missing
Effect	Critical
Care Type(s)	Rehabilitation
Description	The rehabilitation episode does not have a valid Impairment Code recorded. Refer to *Appendix 5: AROC Impairment Types* for permitted values.
Logic	IF Impairment Type (Data Item 8) is blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 2000

Edit Number	2001
Edit Name	Impairment Type is invalid
Effect	Critical
Care Type(s)	Rehabilitation
Description	The rehabilitation episode has an invalid value recorded for Impairment Types. Refer to *Appendix 5: AROC Impairment Types* for permitted values.
Logic	IF Impairment Type (Data item 8) ≠ valid value in *Appendix 5: AROC Impairment Type* AND Impairment Type (Data Item 8) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 2001

Edit Number	3000
Edit Name	HoNOS 65+ assessment is missing
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The psychogeriatric episode is missing the HoNOS 65+ Assessment Date and all HoNOS 65+ Assessment Scores.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS 65+ Assessment Scores (Data Items 27 – 38) are all blank

	AND Admission for Assessment Only ≠ 1 THEN trigger Edit 3000

Edit Number	3001
Edit Name	HoNOS 65+ assessment is not complete
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The psychogeriatric episode has a HoNOS 65+ Assessment Data record but it is missing one or more HoNOS 65+ Assessment Scores.
Logic	IF at least one of HoNOS 65+ Assessment Date (Data Item 6) is blank AND Admission for Assessment Only ≠ 1 AND HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS 65+ Assessment Scores (Data Items 27 – 38) are not all blank THEN trigger Edit 3001

Edit Number	3002
Edit Name	HoNOS 65+ assessment date is missing
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The psychogeriatric episode has HoNOS 65+ Assessment Scores recorded but the HoNOS 65+ Assessment Date is missing.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) is blank AND Admission for Assessment Only ≠ 1 AND HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS65+ Assessment Scores (Data Items 27 – 38) are not all blank THEN trigger Edit 3002

Edit Number	3003
Edit Name	HoNOS 65+ assessment date is prior to admission date
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The HoNOS 65+ Assessment Date is before the Admission Date.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) < Admission Date (Data Item 3) AND HoNOS 65+ Assessment Date (Data Item 6) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 3003

Edit Number	3004
Edit Name	HoNOS 65+ assessment date is after separation date
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The HoNOS 65+ Assessment Date is after the separation date.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) > Separation Date (Data Item 4) AND HoNOS 65+ Assessment Date (Data Item 6) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 3004

Edit Number	3005
Edit Name	HoNOS65+ assessment score(s) is not in range
Effect	Critical
Care Type(s)	Psychogeriatric
Description	One or more of the HoNOS 65+ Assessment Scores recorded is not a valid score. Refer to the relevant Data Definition for permitted values.
Logic	IF HoNOS 65+ Assessment Score(s) (Data Item 27 – 38) ≠ 0, 1, 2, 3 or 4 AND Admission for Assessment Only ≠ 1 AND HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS 65+ Assessment Scores (Data Items 27 – 38) are not <u>all</u> blank THEN trigger Edit 3005

Edit Number	4000
Edit Name	RUG-ADL assessment is missing for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The maintenance episode is missing the RUG-ADL Assessment Data, RUG-ADL Assessment Scores and Type of Maintenance.
Logic	IF RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are <u>all</u> blank THEN trigger edit 4000

Edit Number	4001
Edit Name	RUG-ADL assessment score(s) is not complete
Effect	Critical

Care Type(s)	Maintenance
Description	The maintenance episode has the RUG-ADL Assessment Date and/or the Type of Maintenance Care record but is missing one or more RUG-ADL Assessment Scores.
Logic	IF at least one RUG-ADL Assessment Score(s) (Data Items 48 – 51) is blank AND RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are not <u>all</u> blank THEN trigger Edit 4001

Edit Number	4002
Edit Name	RUG-ADL assessment score(s) is not in range for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	One or more of the RUG-ADL Assessment Scores recorded is not a valid score. Refer to the relevant Data Definition for permitted values.
Logic	IF RUG-ADL Assessment Score(s) (Data Item 48 – 50) ≠ 1, 3, 4 or 5 OR RUG-ADL Assessment Score (Data Item 51) ≠ 1, 2 or 3 AND RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are not <u>all</u> blank THEN trigger Edit 4002

Edit Number	4003
Edit Name	RUG-ADL assessment date is missing for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The maintenance episode has RUG-ADL Assessment Scores recorded but the RUG-ADL Assessment Date is missing.
Logic	AND RUG-ADL Assessment Date (Data Item 6) is blank AND RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are not <u>all</u> blank THEN trigger Edit 4003

Edit Number	4004
Edit Name	RUG-ADL assessment date is prior to admission date for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The RUG-ADL Assessment Date is before the Admission Date.

Logic	IF RUG-ADL Assessment Date (Data Item 6) is > Admission Date (Data Item 3) AND RUG-ADL Assessment Date (Data Item 6) is not blank THEN trigger Edit 4004

Edit Number	4005
Edit Name	RUG-ADL assessment date is after the separation date for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The RUG-ADL Assessment Date is after the Separation Date.
Logic	IF RUG-ADL Assessment Date (Data Item 6) is > Admission Date (Data Item 4) AND RUG-ADL Assessment Date (Data Item 6) is not blank THEN trigger Edit 4005

Edit Number	5000
Edit Name	Phase of care information is missing
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode does not have any Phase of Care information recorded.
Logic	IF Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are <u>all</u> blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5000

Edit Number	5001
Edit Name	Phase of care is missing start and/or end date
Effect	Critical
Care Type(s)	Palliative Care
Description	The Phase of Care Start Date or Phase of Care End Date for one or more phases of care is missing.
Logic	IF Phase of Care Start Date (Data Item 39) OR Phase of Care End Date (Data Item 40) is blank

	AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5001

Edit Number	5002
Edit Name	Phase of care does not cover whole episode duration
Effect	Critical
Care Type(s)	Palliative Care
Description	The Phase of Care Start Date for the first phase of care or the Phase of Care End Date for the last phase of care does not correspond with the Admission and Separation dates for the palliative care episode.
Logic	IF Phase of Care Start Date 1 (Data Item 39) ≠ palliative Admission Date (Data Item 3) OR Phase of Care End Date 1 – 11 (Data Item 40) ≠ palliative Separation Date (Data Item 4) OR Phase of Care End Date 1 (Data Item 40) ≠ Phase of Care Start Date 2 (Data Item 39) OR Phase of Care End Date 2 (Data Item 40) ≠ Phase of Care Start Date 3 (Data Item 39) OR Phase of Care End Date 3 (Data Item 40) ≠ Phase of Care Start Date 4 (Data Item 39) OR Phase of Care End Date 4 (Data Item 40) ≠ Phase of Care Start Date 5 (Data Item 39) OR Phase of Care End Date 5 (Data Item 40) ≠ Phase of Care Start Date 6 (Data Item 39) OR Phase of Care End Date 6 (Data Item 40) ≠ Phase of Care Start Date 7 (Data Item 39) OR Phase of Care End Date 7 (Data Item 40) ≠ Phase of Care Start Date 8 (Data Item 39) OR Phase of Care End Date 8 (Data Item 40) ≠ Phase of Care Start Date 9 (Data Item 39) OR Phase of Care End Date 10 (Data Item 40) ≠ Phase of Care Start Date 11 (Data Item 39) AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42)

	AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5002

Edit Number	5003
Edit Name	Phase of care end date does not correspond with next phase of care start date
Effect	Critical
Care Type(s)	Palliative Care
Description	The Phase of Care End Date for one or more phases does not correspond with the next sequential Phase of Care Start Date. For example, the Phase of Care End Date for the first phase of care should be the same as the Phase of Care Start Date for the second phase of care.
Logic	IF Phase of Care End Date 1 (Data Item 40) ≠ Phase of Care Start Date 2 (Data Item 39) OR Phase of Care End Date 2 (Data Item 40) ≠ Phase of Care Start Date 3 (Data Item 39) OR Phase of Care End Date 3 (Data Item 40) ≠ Phase of Care Start Date 4 (Data Item 39) OR Phase of Care End Date 4 (Data Item 40) ≠ Phase of Care Start Date 5 (Data Item 39) OR Phase of Care End Date 5 (Data Item 40) ≠ Phase of Care Start Date 6 (Data Item 39) OR Phase of Care End Date 6 (Data Item 40) ≠ Phase of Care Start Date 7 (Data Item 39) OR Phase of Care End Date 7 (Data Item 40) ≠ Phase of Care Start Date 8 (Data Item 39) OR Phase of Care End Date 8 (Data Item 40) ≠ Phase of Care Start Date 9 (Data Item 39) OR Phase of Care End Date 10 (Data Item 40) ≠ Phase of Care Start Date 11 (Data Item 39) AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5003

Edit Number	5004

Edit Name	Last phase of care end date is after separation date
Effect	Critical
Care Type(s)	Palliative Care
Description	The end date for the last phase of care is after the separation date.
Logic	The last Phase of Care End Date (Data Item 40) > Separation Date (Data Item 4) AND last Phase of Care End Date 1 – 11 (Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5004

Edit Number	5005
Edit Name	Last phase of care end date is before separation date
Effect	Critical
Care Type(s)	Palliative Care
Description	The end date for the last phase of care is before the separation date.
Logic	The last Phase of Care End Date (Data Item 40) < Separation Date (Data Item 4) AND last Phase of Care End Dates 1 – 11 (Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5005

Edit Number	5006
Edit Name	First phase of care start date is before admission date
Effect	Critical
Care Type(s)	Palliative Care
Description	The start date for the first phase of care is before the admission date
Logic	The first Phase of Care Start Date (Data Item 39) < Admission Date (Data Item 3) AND Phase of Care Start Dates 1(Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5006

Edit Number	5007
Edit Name	First phase of care start is after admission date
Effect	Critical
Care Type(s)	Palliative Care

Description	The start date for the first phase of care is after the admission date
Logic	The first Phase of Care Start Date (Data Item 39) > Admission Date (Data Item 3) AND Phase of Care Start Dates 1(Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5007

Edit Number	5008
Edit Name	Palliative phase of care is missing
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode has palliative care dates or scores recorded but is missing the Palliative Care Phase Type.
Logic	IF Palliative Care Phase Type (Data Item 42) is blank AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5008

Edit Number	5009
Edit Name	Palliative phase of care is invalid
Effect	Critical
Care Type(s)	Palliative Care
Description	One or more of the Palliative Phase of Care Types recorded is not a valid value. Refer to the relevant Data Definition for permitted values.
Logic	IF Palliative Care Phase Type (Data Item 42) ≠ 1, 2, 3, 4 or 9 AND Palliative Care Phase Type (Data Item 42) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5009

Edit Number	5010
Edit Name	RUG-ADL assessment date is before phase of care start date
Effect	Critical
Care Type(s)	Palliative Care

Description	The RUG-ADL Assessment Date for a given phase of care occurs prior to the Phase of Care Start Date. A Phase of Care Start Date must always be before the RUG-ADL Assessment Date.
Logic	IF RUG-ADL Assessment Date (Data Item 41) < corresponding Phase of Care Start Date (Data Item 39) AND RUG-ADL Assessment (Data Item 41) is not blank AND Phase of Care Start Date (Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5010

Edit Number	5011
Edit Name	RUG-ADL assessment date is after phase of care end date
Effect	Critical
Care Type(s)	Palliative Care
Description	The RUG-ADL Assessment Date for a given phase of care occurs after the Phase of Care End Date. A Phase of Care End Date must always be after the RUG-ADL Assessment Date.
Logic	IF RUG-ADL Assessment Date (Data Item 41) > corresponding Phase of Care End Date (Data Item 40) AND RUG-ADL Assessment (Data Item 41) is not blank AND Phase of Care End Date (Data Item 40) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5011

Edit Number	5012
Edit Name	RUG-ADL assessment score(s) missing for palliative phase
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode does not have any Phase of Care information recorded.
Logic	IF at least one RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) is blank AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5012

Edit Number	5013
Edit Name	RUG-ADL assessment score(s) is not in range for palliative phase
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode does not have any Phase of Care information recorded.
Logic	IF RUG-ADL Assessment Score(s) (Data Item 43 – 46) ≠ 1, 3, 4 or 5 OR RUG-ADL Assessment Score (Data Item 51) ≠ 1, 2 or 3 AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5013

Edit Number	5014
Edit Name	RUG-ADL assessment date is missing for palliative phase
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative phase has some phase information recorded but the RUG-ADL Assessment Date is missing.
Logic	AND RUG-ADL Assessment Date (Data Item 42) is blank AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5014

Edit Number	5015
Edit Name	RUG-ADL phase assessment date is prior to admission date for palliative episode
Effect	Critical
Care Type(s)	Palliative Care
Description	The RUG-ADL Assessment Date is before the Admission Date.
Logic	IF RUG-ADL Palliative Phase Assessment Date 1 – 11 (Data Item 42) is >

	Admission Date (Data Item 3) AND RUG-ADL Assessment Date (Data Item 42) is not blank THEN trigger Edit 5015

Edit Number	5016
Edit Name	RUG-ADL phase assessment date is after the separation date for palliative episode
Effect	Critical
Care Type(s)	Palliative Care
Description	The RUG-ADL Assessment Date is after the Separation Date.
Logic	IF RUG-ADL Palliative Phase Assessment Date 1 – 11 (Data Item 42) is > Separation Date (Data Item 4) AND RUG-ADL Assessment Date (Data Item 6) is not blank THEN trigger Edit 5016

Edit Number	6000
Edit Name	Type of maintenance care is missing
Effect	Critical
Care Type(s)	Maintenance
Description	The maintenance episode is missing the Type of Maintenance Care.
Logic	IF Type of Maintenance Care (Data Item 47) is blank THEN trigger Edit 6000

Edit Number	6001
Edit Name	Type of maintenance care is invalid
Effect	Critical
Care Type(s)	Maintenance
Description	One or more of the Type of Maintenance values recorded is not a valid value. Refer to the relevant Data Definition for permitted values.
Logic	IF Type of Maintenance Care ≠ 1, 2, 3, 5 or 8 AND Type of Maintenance Care (Data Item 47) is not blank THEN trigger Edit 6001

Edit Number	9000
Edit Name	Assessment only answer is missing
Effect	Critical

Care Type(s)	Rehabilitation; GEM; Palliative
Description	The Assessment only answer is missing.
Logic	IF Admission for Assessment Only (Data Item 7) is blank THEN trigger Edit 9000

Edit Number	9001
Edit Name	Assessment only answer is invalid
Effect	Critical
Care Type(s)	Rehabilitation; GEM; Psychogeriatric; Palliative
Description	The Assessment only answer is not a valid value. Refer to the relevant Data Definition for permitted values.
Logic	IF Admission for Assessment Only (Data Item 7) ≠ 1, 2 or 9 AND Admission for Assessment Only (Data Item 7) is not blank THEN trigger Edit 9001

Edit Number	9002
Edit Name	Assessment only episode is longer than 3 days
Effect	Critical
Care Type(s)	Rehabilitation; GEM; Psychogeriatric; Palliative
Description	The subacute/non-acute episode indicates that the patient was admitted for more than three days however, the Admission for Assessment Only indicates that they were only assessed with no further subacute/non-acute intervention. Please correct or contact SANADC to verify.
Logic	IF Admission for Assessment Only (Data Item 7) = 1 AND Episode duration > 72 hours THEN trigger Edit 9002

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SECTION 11: REFERENCES

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