ANZHFR Data Dictionary v12: summary of changes

- The changes to the ANZHFR Data Dictionary will apply to patients admitted from 1 January 2020
- All changes to the data variables are described in Data Dictionary v12

Version	Variable #	Description of Change	Previous Value v11	New Value or Additions in v12
12	**All date variables**	Default format when date is not known	99999999	01011900
12	**4.11 Patient Level Audit**	**First day mobilisation** Addition to comments		Pedersen MM, Bodilsen AC, Petersen J, Beyer N, Andersen O, Lawson-Smith L, et al. 2013. Twenty-four-hour mobility during acute hospitalization in older medical patients. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 68(3):331-7.
12	**4.15 Patient Level Audit**	**Specialist falls assessment** Addition of examples to comments to improve quality of data	A specialist falls assessment is undertaken by a multidisciplinary team and includes a systematic assessment by a suitably trained person (i.e. geriatrician or a specialist assessment trained nurse), which must go over the following domains: (i) falls history (noting previous falls); (ii) cause of index fall (including medication review); (iii) risk factors for falling and injury (including fracture) and from this information formulate and document an individualised plan of action to prevent further falls. A specialist falls assessment is not a screening tool.	Example 1: Patient admitted with a hip fracture and managed surgically. During the post-operative period in the acute ward, a specialist falls assessment was commenced with documented assessment of falls risk and medication review. In the medical record there was a documented referral to the specialist falls service to be actioned on discharge from acute care. Option 2 would be selected. Example 2: Patient admitted with a hip fracture and managed surgically. During the post-operative period in the acute ward, a specialist falls assessment was commenced with documented assessment of falls risk factors, falls history and cause of index fall. There was no other documentation of assessment or referral. Option 0 would be selected.
12	**4.16/7.07 Patient Level Audit**	**Bone protection medication at discharge from acute hospital/at 120 day follow up** Changes to coding frame – removal of strontium from option 2	0 No bone protection medication 1 Yes - Calcium and/or vitamin D only 2 Yes - Bisphosphonates, strontium, denosumab or teriparatide (with or without calcium and/or vitamin D) 9 Not known	0 No bone protection medication 1 Yes - Calcium and/or vitamin D only 2 Yes - Bisphosphonates, denosumab or teriparatide (with or without calcium and/or vitamin D) 9 Not known
12	**4.17 Patient Level Audit**	**Delirium assessment** Addition to comments		Addition of the 4AT (Bellelli et al. 2014) to the list of validated diagnostic tools for assessment of delirium.
12	**4.19 Patient Level Audit**	**First day walking mobil2** New variable		Did the patient get out of bed and walk on day one post hip fracture surgery? 0 No 1 Yes 9 Not known

12	**7.05 Patient Level Audit**	**Full weight bear at 120 day follow up** Retired variable	Is the patient allowed full weight bearing at 120 day follow-up? 0 Unrestricted weight bearing 1 Restricted / non weight bearing 8 Not relevant 9 Not known	Retired
12	**7.09 Patient Level Audit**	**Preliminary date of death** New variable – collected by sites		What was the date of death of the hip fracture patient? DD/MM/YYYY Date not known is recorded as: 01011900. Date of death may be collected either at discharge or during 120-day follow-up.
12	**7.10 Patient Level Audit**	**Final date of death** New variable – collected by the ANZHFR via data linkage		What was the date of death of the hip fracture patient? DD/MM/YYYY Date not known is recorded as: 01011900. Final Australian date of death will be obtained from the National Death Index and final New Zealand date of death will be obtained from the New Zealand Ministry of Health.
12	**7.11 Patient Level Audit**	**Underlying cause of death** New variable – collected by the ANZHFR via data linkage		What was the underlying cause of death of the hip fracture patient? ICD-10 Australian underlying cause of death obtained from the National Death Index. New Zealand underlying cause of death obtained from the New Zealand Ministry of Health. The disease or injury which initiated the train of morbid events leading directly to a person's death or the circumstances of the incident or violence which produced the fatal injury.
12	**7.12 Patient Level Audit**	**Other causes of death** New variable – collected by the ANZHFR via data linkage		What was the underlying cause of death of the hip fracture patient? ICD-10 Australian other cause(s) of death obtained from the National Death Index. New Zealand other cause(s) of death obtained from the New Zealand Ministry of Health. The disease or injury which initiated the train of morbid events leading directly to a person's death or the circumstances of the incident or violence which produced the fatal injury.
12	**10.10 Facility Level Audit**	**Delirium tool** What tool is used to assess delirium in hip fracture patients?		1 Confusion Assessment Method (CAM)35,36 2 Confusion Assessment Method (CAM-ICU)37 3 3D-CA 4 4AT 8 Other 9 Not Known
12	**10.11 Facility Level Audit**	**Frailty index** Which tool does your hospital use to assess the frailty status of individual hip fracture patients?		0 Frailty not collected 1 Clinical Frailty Scale 2 Frailty Index 3 Hospital Fragility Risk Index 8 Other 9 Not Known