ANZHFR
Australian & New Zealand Hip Fracture Registry

ANZHFR Concordance tables - Patient-level audit

The concordance tables outline modifications to patient-level data variables that have occurred in the ANZHFR over time.

Section 2

Number	**Variable**	**Old definition**	**Revised definition**
2.13	Pain management	Did the patient receive ~~appropriate~~ analgesia within 30 minutes of presentation to the emergency department?	Did the patient receive analgesia within 30 minutes of presentation to the emergency department? **[‘appropriate’ removed from 1 Jan 2021]**

Section 3

Number	**Variable**	**Old DD comments**	**Revised DD comments**
3.01	Pre-admission walking ability	(Blank)	If a person has different levels of mobility on different surfaces then record the level of most assistance. For example, inside their residence a person usually walks without a walking aid but when outside the residence the person usually walks with a frame, then the level of mobility recorded is option 3. **[Added 1 Jan 2019]**

Number	Variable	Old coding frame		Revised coding frame	
3.02	Pre-operative cognitive assessment	1	Not assessed	1	Not assessed
		2	Assessed and normal	2	Assessed and normal
		3	Assessed and abnormal or impaired	3	Assessed and abnormal or impaired
		8	Cognition assessed using validated tool and recorded **[Retired 31 December 2017]**	9	Not known
		9	Not known		
Classification note: Code '8' in the old coding frame does not equate to any codes in the revised coding frame. Any patient with a code '8' prior to 31 Dec 2017 should be coded '9' for pre-operative cognitive status.					

Number	Variable	Old coding frame		Revised coding frame	
3.05	Pre-admission cognitive status	1	Normal cognition	1	Normal cognition
		2	Impaired cognition or known dementia	2	Impaired cognition or known dementia
		8	Not assessed **[Retired 31 December 2017]**	9	Not known
		9	Not known		
Classification note: Code '8' in the old coding frame does not equate to any codes in the revised coding frame. Any patient with a code '8' prior to 31 Dec 2017 should be coded '9' for pre-admission cognitive status.					

Number	Variable	Old coding frame		Revised coding frame	
3.11	Surgical repair	1	No **[retired 31 Dec 2020]**		
		2	Yes	2	Yes
				3	No- surgical fixation not clinically indicated **[Added 1 Jan 2021]**
				4	No- patient for palliation **[Added 1 Jan 2021]**
				5	No- other reason **[Added 1 Jan 2021]**

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Definition</th></tr>
<tr><td rowspan="20">3.13</td><td rowspan="20">Clinical Frailty Scale
[New variable added 1 Jan 2021]</td><td colspan="2">What was the patient’s pre-injury frailty status?</td></tr>
<tr><td colspan="2">**Justification**</td></tr>
<tr><td colspan="2">To enable the identification of the patient’s frailty status prior to their hip fracture as a person’s level of frailty impacts outcomes. .</td></tr>
<tr><td colspan="2">**Coding source**</td></tr>
<tr><td colspan="2">Rockwood Clinical Frailty Scale</td></tr>
<tr><td colspan="2">**Coding frame**</td></tr>
<tr><td>1</td><td>Very fit</td></tr>
<tr><td>2</td><td>Well</td></tr>
<tr><td>3</td><td>Well, with treated comorbid disease</td></tr>
<tr><td>4</td><td>Vulnerable</td></tr>
<tr><td>5</td><td>Mildly frail</td></tr>
<tr><td>6</td><td>Moderately frail</td></tr>
<tr><td>7</td><td>Severely frail</td></tr>
<tr><td>8</td><td>Very severely frail</td></tr>
<tr><td>9</td><td>Terminally ill</td></tr>
<tr><td>99</td><td>Not known</td></tr>
<tr><td colspan="2">**DD comments**</td></tr>
<tr><td colspan="2">NOTE: the Clinical Frailty Scale applies to the person’s usual status prior to the hip fracture. Where the person has dementia or delirium the information will need to be provided by an informant who knows the person well.
Coding Frame Definitions
1 **Very fit** - robust, active, energetic and well-motivated. Exercise regularly and are among the fittest for their age.
2 **Well** - without active disease symptoms but are less fit than category 1. Exercise occasionally.
3 **Well with treated comorbid disease** - disease symptoms are well controlled compared to category four. Not regularly active beyond routine walking.
4 **Vulnerable** - not dependent on others for daily help, but symptoms limit activities. Common complaint is being ‘slowed up’ or being tired during the day.
5 **Mildly frail** - more evident slowing, and need help in instrumental activities of daily living (e.g. heavy housework, medications, transportation, shopping, using the phone, managing finances, meal preparation).
6 **Moderately frail** - need help with both instrumental and non-instrumental activities of daily living. Includes mobility in bed, transferring on/off chairs, toilets and into/out of bed, walking, dressing, eating, toilet use, personal hygiene, bathing.
7 **Severely frail** - completely dependent on others for all activities of daily living for whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
8 **Very severely frail** - completely dependent on others for all activities of daily living, approaching the end of life. Typically, they could not recover even from a minor illness.
9 **Terminally ill** - approaching the end of life. Applies to people with a life expectancy <6 months who are not otherwise evidently frail.</td></tr>
</table>

Section 4

Number	Variable	Old coding frame		Revised coding frame	
4.03	Surgery delay	1	No delay, surgery completed <48 hours	1	No delay, surgery completed <48 hours
		2	Delay due to patient deemed medically unfit	2	Delay due to patient deemed medically unfit
		3	Delay due to issues with anticoagulation	3	Delay due to issues with anticoagulation
		4	Delay due to theatre availability	4	Delay due to theatre availability
		5	Delay due to surgeon availability	5	Delay due to surgeon availability
		7	Other type of delay	6	Delay due to delayed diagnosis of hip fracture **[Added 1 Jan 2017]**
		9	Not known	7	Other type of delay
				9	Not known
		Old DD comments		**Revised DD comments**	
		Delay is calculated from the time of presentation in the emergency department of the first hospital. A person is considered medically unfit if he/she have acute health-related issues which need to be stabilised/optimised or reversed prior to proceeding with anaesthesia and a surgical procedure.		Delay is calculated from the time of presentation in the emergency department of the first hospital. A person is considered medically unfit if he/she have acute health-related issues which need to be stabilised/optimised or reversed prior to proceeding with anaesthesia and a surgical procedure. If there is more than one delay to surgery, choose the reason for the first delay. **[Added 1 Jan 2019]**	

Number	Variable	Old coding frame		Revised coding frame	
4.05	Type of anaesthesia	1	General anaesthesia	1	General anaesthesia
		5	Spinal / regional anaesthesia	2	
		97	Other	5	Spinal / regional anaesthesia
		99	Not known	6	General and spinal / regional anaesthesia **[Added 1 Jan 2017]**
				97	Other
				99	Not known

Number	Variable	Old DD comments	Revised DD comments
4.07	Consultant surgeon present	Identified by checking if the consultant surgeon is recorded on the operation sheet	To record yes, consultant must be scrubbed and operating. This variable can be found by checking if the consultant surgeon is recorded on the operation sheet **[Added 1 Jan 2021]**

Number	Variable	Old coding frame		Revised coding frame	
4.11	First mobilisation	0	Patient out of bed and given opportunity to start mobilising day 1 post surgery	0	Patient given opportunity to start mobilising day 1 post surgery **[Amended 1 Jan 2019]**
		1	Patient not given opportunity to start mobilising day 1 post surgery	1	Patient not given opportunity to start mobilising day 1 post surgery
		9	Not known	9	Not known
		Old DD comments		**Revised DD comments**	
		Day 1 post-surgery means the next calendar day following the day of the patient's primary surgery for hip fracture. Mobilised means the patient was sat out of bed and given the opportunity to start mobilising on day 1 post hip fracture surgery. Mobility may include getting in/out of bed, standing up from a chair, and/or walking. Patients who have been given the opportunity to mobilise but are determined by the clinical team to be too unwell to mobilise are included provided both the opportunity to mobilise and the clinical determination are documented in the medical record. Patients that have declined to mobilise are included provided both the opportunity to mobilise and the reason for declining are documented in the medical record.		Day 1 post-surgery means the next calendar day following the day of the patient's primary surgery for hip fracture. Mobilised means the patient was sat out of bed and given the opportunity to start mobilising on day 1 post hip fracture surgery. Mobility may include getting in/out of bed, standing up from a chair, and/or walking. Patients who have been given the opportunity to mobilise but are determined by the clinical team to be too unwell to mobilise are included provided both the opportunity to mobilise and the clinical determination are documented in the medical record. Patients that have declined to mobilise are included provided both the opportunity to mobilise and the reason for declining are documented in the medical record. 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. **[Added 1 Jan 2020]**	

Number	Variable	Old DD comments	Revised DD comments
4.15	Specialist falls assessment	A specialist falls assessment 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 a plan of action to prevent further falls	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 **[Added 1 Jan 2019]**
		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	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. **[Added 1 Jan 2020]**

Number	Variable	Old coding frame		Revised coding frame	
4.16	Bone protection medication at discharge from acute hospital	0	No bone protection medication	0	No bone protection medication
		1	Yes calcium and/or vitamin D only	1	Yes - Calcium and/or vitamin D only
		2	Yes bisphosphonates, denosumab or teriparatide (with or without calcium and/or vitamin D) **[strontium removed from 1 January 2020]**	2	Yes - Bisphosphonates, denosumab or teriparatide (with or without calcium and/or vitamin D)
		9	Not known	9	Not known

Number	Variable	Old DD comments	Revised DD comments
4.17	Delirium assessment	Assessment of delirium requires the use of a validated tool. There are a range of validated diagnostic tools for delirium and they include: • Confusion Assessment Method (CAM) (Inouye et al. 2014; Shi et al. 2013) • Confusion Assessment Method (CAM-ICU) (Ely et al. 2001) • 3D-CAM (Marcantonio et al. 2014). If a person declines assessment record as not assessed. Delirium is defined as an acute change in mental status that is common among older patients in hospital (Clinical Epidemiology and Health Service Evaluation Unit 2006). It is characterised by a disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days) (National Institute for Health and Clinical Excellence 2010; Inouye 2014). Patients with delirium may be agitated and restless (hyperactive delirium), quiet and withdrawn (hypoactive delirium), or move between these two subtypes (mixed delirium) (Clinical Epidemiology and Health Service Evaluation Unit 2006; National Institute for Health and Clinical Excellence 2010).	Assessment of delirium requires the use of a validated tool. There are a range of validated diagnostic tools for delirium and they include: • Confusion Assessment Method (CAM) (Inouye et al. 2014; Shi et al. 2013) • Confusion Assessment Method (CAM-ICU) (Ely et al. 2001) • 3D-CAM (Marcantonio et al. 2014). • The 4AT (Bellelli et al. 2014) **[Added 1 Jan 2020]** If a person declines assessment record as not assessed. Delirium is defined as an acute change in mental status that is common among older patients in hospital (Clinical Epidemiology and Health Service Evaluation Unit 2006). It is characterised by a disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days) (National Institute for Health and Clinical Excellence 2010; Inouye 2014). Patients with delirium may be agitated and restless (hyperactive delirium), quiet and withdrawn (hypoactive delirium), or move between these two subtypes (mixed delirium) (Clinical Epidemiology and Health Service Evaluation Unit 2006; National Institute for Health and Clinical Excellence 2010).

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Definition</th></tr>
<tr><td rowspan="12">4.18</td><td rowspan="12">Clinical malnutrition assessment

[New variable added 1 Jan 2019]</td><td colspan="2">Did the patient undergo clinical assessment of their protein/energy nutrition status during the acute phase of the episode of care?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">Hip fracture patients are at high risk of malnutrition. Malnutrition in these patients is associated with increased morbidity and mortality, and a decrease in return to pre-fracture functioning.</td></tr>
<tr><td colspan="2">Coding Source</td></tr>
<tr><td colspan="2">Adapted from the UK National Hip Fracture Database</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td>0</td><td>Not done</td></tr>
<tr><td>1</td><td>Malnourished</td></tr>
<tr><td>2</td><td>Not malnourished</td></tr>
<tr><td>9</td><td>Not known</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">Clinical assessment of a person’s nutritional status is encouraged during the acute phase. Sites should use tools that are validated for such purposes, and are advised to discuss with their Dietitians how best to record the results using this variable’s options.

If the nutritional assessment is performed more than once, please record the first assessment after admission that uses a validated tool.</td></tr>
</table>

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Definition</th></tr>
<tr><td rowspan="13">4.19</td><td rowspan="13">First day walking

[New variable added 1 Jan 2020]</td><td colspan="2">Did the patient get out of bed and walk on day one post hip fracture surgery?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">Hip Fracture Care Clinical Care Standard Indicator 5a. Low mobility during hospitalisation is associated with death, and declining function in activities of daily living at discharge and at one month follow-up, which induces a risk of staying dependent in these activities (Pedersen et al. 2013).</td></tr>
<tr><td colspan="2">Coding Source</td></tr>
<tr><td colspan="2">Adapted from the UK National Hip Fracture Database</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td>0</td><td>No</td></tr>
<tr><td>1</td><td>Yes</td></tr>
<tr><td>9</td><td>Not known</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">Day 1 post-surgery means the next calendar day following the day of the patient’s primary surgery for hip fracture.

Mobilised means the patient managed to stand and step transfer out of bed onto a chair/commode and or walk. This does not include only sitting over the edge of the bed or standing up from the bed without stepping/walking.

This data item is recording whether the patient actually stood and stepped or walked on day 1 post-surgery. Potential reasons a patient may not mobilise are: symptomatic postural hypotension, delirium (usually hypoactive) or uncontrolled pain despite pain relief. A reason must be recorded in the patient’s medical record.

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.</td></tr>
</table>

Section 6

Number	Variable	Old	Revised
6.01	30 day follow up date	**Definition**	**[Retired 1 Jan 2019]**
		Date on which the 30 day follow-up was completed post the initial hip fracture surgery.	
		Justification	
		To monitor patient outcomes post-surgery	
		Coding frame	
		DDMMYYYY	
		DD comments	
		Date not known is entered as: 99999999	

Number	Variable	Old	Revised
6.02	Survival at 30 days post-surgery	**Definition**	**[Retired 1 Jan 2019]**
		Is the patient alive at 30 days post-surgery?	
		Justification	
		To monitor patient outcomes post-surgery. Hip Fracture Care Clinical Care Standard Indicator 8b	
		Coding frame	
		0 No	
		1 Yes	
		9 Not known	
		DD comments	
		If the answer is no, variables 6.03 to 6.08 are automatically filled as 'not relevant'	

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Old</th><th>Revised</th></tr>
<tr><td rowspan="8">6.03</td><td rowspan="8">Date health system discharge at 30 day follow-up</td><td colspan="2">Definition</td><td rowspan="8">[Retired 1 Jan 2019]</td></tr>
<tr><td colspan="2">What date was the patient finally discharged from the health system?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">To enable the identification of the total length of stay in the health system</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td colspan="2">DDMMYYYY</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">If the patient is still in hospital, 00000000 is entered. Date not known is entered as: 99999999</td></tr>
</table>

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Old</th><th>Revised</th></tr>
<tr><td rowspan="16">6.04</td><td rowspan="16">Place of residence at 30 day follow-up</td><td colspan="2">Definition</td><td rowspan="16">[Retired 1 Jan 2019]</td></tr>
<tr><td colspan="2">What is the place of residence of the person at 30 days post-surgery?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">To monitor patient outcomes post-surgery</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td>1</td><td>Private residence (including unit in retirement village)</td></tr>
<tr><td>2</td><td>Residential aged care / rest home</td></tr>
<tr><td>3</td><td>Rehabilitation unit public</td></tr>
<tr><td>4</td><td>Rehabilitation unit private</td></tr>
<tr><td>5</td><td>Other hospital / ward / specialty</td></tr>
<tr><td>6</td><td>Deceased</td></tr>
<tr><td>7</td><td>Short term care in residential care facility (New Zealand only)</td></tr>
<tr><td>97</td><td>Other</td></tr>
<tr><td>99</td><td>Not known</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">Record the patient's discharge destination at 30 days post-surgery. If the patient is discharged to live with a relative or in a community group home or boarding house code ‘private residence’. Private rehabilitation units will not be applicable in New Zealand.</td></tr>
</table>

		Residential aged care refers to a supported facility that provides accommodation and care for a person on a long-term basis. This may include multi-purpose services in Australia and private hospitals or rest homes in New Zealand. Short-term care in residential care facility may be relevant if the patient is non-weight bearing and is used in New Zealand and to a lesser degree in Australia. For example, in New Zealand, some District Health Boards have programmes that fund patients who are non-weight bearing to be cared for in a residential care facility. When they are approved by the Orthopaedic Department to fully weight bear they are either admitted to Older Peoples Health for rehabilitation or discharged home.	

Number	Variable	Old	Revised
6.05	Full weight bear at 30 day follow-up	**Definition** Is the patient allowed full weight bearing at 30 day follow-up? **Justification** Ability to monitor variation in clinical practice **Coding frame** 0 Unrestricted weight bearing 1 Restricted / non weight bearing 8 Not relevant 9 Not known **DD comments** Unrestricted weight bearing refers to a patient who is able to mobilise with full use of the affected limb to weight bear as pain allows. Restricted weight bearing refers to a patient where there is a specific instruction that prevents the patient being allowed to fully utilise the leg irrespective of degree of pain. Restricted weight bearing includes terms such as partial weight bear, touch-weight bear and non-weight bear	**[Retired 1 Jan 2019]**

Number	Variable	Old	Revised
6.06	Post-admission walking ability at 30 day follow-up	**Definition** What was the patient's walking ability at 30 days post-surgery? **Justification** To monitor patient mobility status post-discharge **Coding frame** 1 Usually walks without walking aids 2 Usually walks with either a stick or crutch 3 Usually walks with two aids or frame (with or without assistance of a person) 4 Usually uses a wheelchair / bed bound 8 Not relevant 9 Not known **DD comments**	**[Retired 1 Jan 2019]**

		Usually walks with two aids or frame includes with or without assistance of a person	

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Old</th><th>Revised</th></tr>
<tr><td rowspan="12">6.07</td><td rowspan="12">Bone protection medication at 30 day follow-up</td><td colspan="2">Definition</td><td rowspan="12">[Retired 1 Jan 2019]</td></tr>
<tr><td colspan="2">What bone protection medication was the patient using at 30 days post-surgery?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">Ability to monitor use of bone protection medication</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td>0</td><td>No bone protection medication</td></tr>
<tr><td>3</td><td>Yes - Calcium and/or vitamin D only</td></tr>
<tr><td>4</td><td>Yes - Bisphosphonates, strontium, denosumab or teriparitide (with or without calcium and/or vitamin D)</td></tr>
<tr><td>9</td><td>Not known</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">Calcium or vitamin D includes Calcitriol, calcium and vitamin D or Alpha-calcidol (or one alpha).

Bisphosphonates includes: Etidronate, Alendronate, Risedronate, Ibandronate, Zoledronate, Pamidronate.</td></tr>
</table>

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Old</th><th>Revised</th></tr>
<tr><td rowspan="18">6.08</td><td rowspan="18">Re-operation within 30 day follow-up</td><td colspan="2">Definition</td><td rowspan="18">[Retired 1 Jan 2019]</td></tr>
<tr><td colspan="2">What kind of re-operation has been required (if any) for the patient within 30 days post-surgery?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">To monitor patient outcomes post-surgery. Hip Fracture Care Clinical Care Standard Indicator 8a.</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td>0</td><td>No reoperation at 30 days post surgery</td></tr>
<tr><td>1</td><td>Reduction of dislocated prosthesis</td></tr>
<tr><td>2</td><td>Washout or debridement</td></tr>
<tr><td>3</td><td>Implant removal</td></tr>
<tr><td>4</td><td>Revision of internal fixation</td></tr>
<tr><td>5</td><td>Conversion to hemiarthropasty</td></tr>
<tr><td>6</td><td>Conversion to total hip replacement</td></tr>
<tr><td>7</td><td>Excision arthroplasty</td></tr>
<tr><td>9</td><td>Revision arthroplasty</td></tr>
<tr><td>99</td><td>Not know</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">Option 2 washout or debridement includes liner changes. Note: record the most significant procedure only.</td></tr>
</table>

Section 7

<table>
<tr><th>Number</th><th>Variable</th><th colspan="2">Old</th><th>Revised</th></tr>
<tr><td rowspan="12">7.05</td><td rowspan="12">Full weight bear at 120 day follow-up</td><td colspan="2">Definition</td><td rowspan="12">[Retired 1 Jan 2020]</td></tr>
<tr><td colspan="2">Is the patient allowed full weight bearing at 120 day follow-up?</td></tr>
<tr><td colspan="2">Justification</td></tr>
<tr><td colspan="2">Ability to monitor variation in clinical practice</td></tr>
<tr><td colspan="2">Coding frame</td></tr>
<tr><td>0</td><td>Unrestricted weight bearing</td></tr>
<tr><td>1</td><td>Restricted / non weight bearing</td></tr>
<tr><td>8</td><td>Not relevant</td></tr>
<tr><td>9</td><td>Not known</td></tr>
<tr><td colspan="2">DD comments</td></tr>
<tr><td colspan="2">Unrestricted weight bearing refers to a patient who is able to mobilise with full use of the affected limb to weight bear as pain allows.

Restricted weight bearing refers to a patient where there is a specific instruction that prevents the patient being allowed to fully utilise the leg irrespective of degree of pain. Restricted weight bearing includes terms such as partial weight bear, touch-weight bear and non-weight bear</td></tr>
</table>

Number	Variable	Old DD comments	Revised DD comments
7.06	Post-admission walking ability at 120 day follow-up	Usually walks with two aids or frame includes with or without assistance of a person	Usually walks with two aids or frame includes with or without assistance of a person If a person has different levels of mobility on different surfaces then record the level of most assistance. For example, inside their residence a person usually walks with no walking aid but when outside the residence the person usually walks with a frame, then the level of mobility recorded is option 3. **[Added 1 Jan 2019]**

Number	Variable	Old coding frame		Revised coding frame	
7.07	Bone protection medication at 120 day follow-up	0	No bone protection medication	0	No bone protection medication
		1	Yes - calcium and/or vitamin D only	1	Yes - calcium and/or vitamin D only
		2	Yes - bisphosphonates, denosumab or teriparatide (with or without calcium and/or vitamin D) **[strontium removed 31 December 2019]**	2	Yes - bisphosphonates, denosumab or teriparatide (with or without calcium and/or vitamin D)
		9	Not known	9	Not known
Classification note: Code '2' in the revised coding frame does not include strontium from 31 December 2019					

Number	Variable	Old coding frame		Revised coding frame	
7.08	Re-operation within 120 day follow-up	0	No reoperation	0	No reoperation
		1	Reduction of dislocation prosthesis	1	Reduction of dislocation prosthesis
		2	Washout or debridement	2	Washout or debridement
		3	Implant removal	3	Implant removal
		4	Revision of internal fixation	4	Revision of internal fixation
		5	Conversion to hemiarthroplasty	5	Conversion to hemiarthroplasty
		6	Conversion to total hip replacement	6	Conversion to total hip replacement
		7	Excision arthroplasty	7	Excision arthroplasty
		8	Periprosthetic fracture **[Retired 31 January 2016]**	9	Revision arthroplasty
		9	Revision arthroplasty	99	Not known
		98	Not relevant **[retired 31 December 2016]**		
		99	Not known		
Classification note: Code '8' in the old coding frame does not equate to any codes in the revised coding frame. Any patient with a code '8' prior to 31 Jan 2016 should be coded '99' for Re-operation within 120 day follow-up. Code '98' in the old coding frame does not have an equivalent value in the revised coding frame. However, patient who have died within the 120-day follow-up period could be classified as '98 – not relevant' during data analysis.					

Number	Variable	Definition
7.09	Preliminary date of death **[New variable- collected by sites, added 1 Jan 2020]**	What was the date of death of the hip fracture patient?
		Justification
		To monitor patient outcomes and enable reporting of mortality after hip fracture Hip Fracture Care Clinical Care Standard Indicator 8b.
		Coding source
		National Health Data Dictionary, Version 15 (METeOR identifier 646025). Preliminary Australian date of death obtained from hospital records and/or during 120 day follow-up.
		Coding frame
		DD/MM/YYYY
		DD comments
		Date not known is recorded as: 01011900 Date of death may be collected either at discharge or during 120-day follow-up. New Zealand date of death may be obtained from the New Zealand Ministry of Health.

Number	Variable	Definition
7.10	Final date of death **[New variable- collected by ANZHFR via data linkage with the National Death Index, added 1 Jan 2020]**	What was the date of death of the hip fracture patient?
		Justification
		To monitor patient outcomes and enable reporting of mortality after hip fracture Hip Fracture Care Clinical Care Standard Indicator 8b.
		Coding Source
		National Health Data Dictionary, Version 15 (METeOR identifier 646025). Final Australian date of death obtained from the National Death Index. New Zealand date of death obtained from the New Zealand Ministry of Health.
		Coding frame
		DD/MM/YYYY
		DD comments
		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.

Number	Variable	Definition
7.11	Underlying cause of death **[New variable- collected by ANZHFR via data linkage with the National Death Index, added 1 Jan 2020]**	What was the underlying cause of death of the hip fracture patient?
		Justification
		To enable identification of the underlying cause of death of the hip fracture patient
		Coding Source
		National Health Data Dictionary, Version 15 (METeOR identifier 307862). 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.
		Coding frame
		ICD-10
		DD comments
		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.

Number	Variable	Definition
7.12	Other causes of death **[New variable- collected by ANZHFR via data linkage with the National Death Index, added 1 Jan 2020]**	What was the underlying cause of death of the hip fracture patient?
		Justification
		To enable identification of the underlying cause of death of the hip fracture patient
		Coding Source
		National Health Data Dictionary, Version 15 (METeOR identifier 307862). 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.
		Coding frame
		ICD-10
		DD comments
		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.