Acute Stroke Services Audit (2021)
Clinical Audit

Core (mandatory) questions

To create a new record within the Australian Stroke Data Tool (AuSDaT) you must enter the following information:

- Patient first name
- Patient surname
- Date of Birth
- Gender

This will create an episode identification number and statistical linkage key or SLK (which will track/link all the individual patient's episodes). First and last name are **not** accessed by the Stroke Foundation and only entered to automatically create an episode.

*Please refer to **2021 Acute Audit Clinical Audit Data Dictionary** for more specific details on the Clinical Audit variables.

AuSDaT ref	Question	Responses	Comment
	AUDITOR INFORMATION		
1.000	Hospital name	NA	Automatically completed
1.020	Auditor name	NA	Automatically completed
1.030	Auditor email	NA	Automatically completed
1.050	Auditor discipline	Doctor; Nurse; Allied health; Manager; Other	
	PATIENT DEMOGRAPHICS		
2.000	Patient episode ID number	NA	Automatically assigned
	First name		Set up new record ONLY
	Last name		Set up new record ONLY
2.090	Date of birth	DDMMYYYY	
2.100	Age	NA	Automatically derived from DOB
2.130	Gender	Male; Female; Intersex or indeterminate; Not stated/inadequately described	
2.170	Interpreter needed?	Yes / No	
2.180	Is the patient of Aboriginal/Torres Strait Islander origin?	Aboriginal but not Torres Strait Islander origin; Torres Strait Islander but not Aboriginal origin; Both Aboriginal and Torres Strait Islander origin; Neither Aboriginal nor Torres Strait Islander origin; Indigenous not otherwise described; Missing / not stated	

Acute Stroke Services Audit (2021)
Clinical Audit

AuSDaT ref	Question	Responses	Comment
	ADMISSION AND TRANSFER INFORMATION		
4.000-4.020	Onset date	DDMMYYYY; Unknown	
4.030-4.070	Onset time	hh:mm Known (accurate) time of onset; If uncertain time of stroke, then time last seen well; If wake up stroke, then time last seen well; Time unknown	
4.140	Did the stroke occur while the patient was in hospital?	Yes / No / Unknown	
4.150 - 4.160	Date of arrival to emergency department	DDMMYYYY	
4.170 - 4.180	Time of arrival to emergency department	hh:mm; Unknown	
4.200	Did the patient arrive by ambulance?	Yes / No / Unknown	
4.220	Was the patient transferred from another hospital?	Yes / No / Unknown	
4.230	Was the patient transferred to another hospital for acute care after admission to your hospital?	Yes / No	
4.240	Date of transfer	DDMMYYYY or Not Documented	
4.260	Time of transfer	Hh:mm: Unknown	
4.290	Date of admission to hospital	DDMMYYYY	
4.320 / 4.331	Time of admission to hospital	hh:mm; Unknown	
4.360 – 4.370	What was the ward for initial admission?	Stroke Unit; ICU/HDU; Other (specify)	
4.380	Was the patient treated in a stroke unit at any time during their stay?	Yes / No / Unknown	
4.390	If yes, date of admission to stroke unit	DDMMYYYY	
4.400 - 4.410	If yes, time of admission to stroke unit	hh:mm; Not documented	
4.420	If yes, date of discharge from stroke unit	DDMMYYYY	
	PRE STROKE HISTORY		
6.000	Did the patient have any history of known risk factors prior to admission?		

Acute Stroke Services Audit (2021)
Clinical Audit

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6.010	Atrial fibrillation	Yes / No / Not documented	
6.020	Previous stroke	Yes / No / Not documented	
6.050	Previous TIA	Yes / No / Not documented	
6.120	Ischaemic heart disease	Yes / No / Not documented	
6.180	Dementia	Yes / No / Not documented	
	Dependency prior to admission		
6.470	Functional status prior to stroke? (mRS) Score 0-5	0-5 (derived if needed)	
6.540	Living arrangements prior to admission?	Home (alone); Home (with others); Supported accommodation e.g. nursing home, hostel; Other	
	ACUTE CLINICAL DATA		
7.020	Did the patient have a validated stroke screen in ED	Yes / No / Unknown	
7.160	Was the primary intent of treatment palliative care?	Yes / No / Unknown	
7.170	If yes, when was the decision made?	DDMMYYYY	
7.201	Was the patient unresponsive (or in a coma)	Yes / No / Not documented	
7.410	Did the patient have a brain scan after this stroke?	Yes / No	
7.420	Was brain scan done within your hospital	Yes / No, done elsewhere	
7.430	Date of first brain scan after the stroke	DDMMYYYY	
7.440 / 7.450	Time of first brain scan after the stroke	hh:mm; Not documented	
7.460	What type of brain scan was performed?	CT; MRI; BOTH CT & MRI	
7.470	Was advanced imaging performed	Yes / No	New Question 2021
7.471	CT angiography	Yes / No	New Question 2021
7.472	CT perfusion	Yes / No	New Question 2021
7.550	Type of stroke	TIA; Ischaemic; Haemorrhage; Undetermined	
7.670	Did the patient have an investigation of the carotid arteries while in hospital?	Yes / No	
	TELEMEDICINE AND REPERFUSION		

AuSDaT ref	Question	Responses	Comment
8.120	Was the patient screened for eligibility for intravenous thrombolysis?	Yes / No	
8.130	Did the patient receive intravenous thrombolysis?	Yes / No / Unknown	
8.140	If Yes, date of delivery?	DDMMYYYY	
8.150	If Yes, time of delivery?	hh:mm	
	OTHER CLINICAL INFORMATION		
	Impairments on admission		
	On admission were any of the following impairments present?		
9.000	Sensory deficit	Yes / No / Not documented	
9.010	Cognitive deficit	Yes / No / Not documented	
9.020	Visual deficit	Yes / No / Not documented	
9.030	Perceptual deficit	Yes / No / Not documented	
9.040	Speech/communication impairment	Yes / No / Not documented	
9.050	Hydration problems	Yes / No / Not documented	
9.060	Nutrition problems	Yes / No / Not documented	
9.061	Arm deficit	Yes / No / Not documented	
9.062	Lower limb deficit	Yes / No / Not documented	
9.063	Dysphagia	Yes / No / Not documented	
9.064	Continence	Yes / No / Not documented	
9.065	Balance	Yes / No / Not documented	
9.066	Other	Yes / No / Not documented	
	Swallowing		
9.070	Was a formal swallowing screen performed (i.e. not a test of gag reflex)?	Yes / No / Not documented	
9.080	Date of screening	DDMMYYYY	
9.100 / 9.101	Time of screening	hh:mm; Unknown	
9.120	Did the patient pass the screening?	Yes / No / Not documented	
9.130	Was a swallowing assessment by a speech pathologist recorded?	Yes / No / Not documented	
9.140	Date of swallowing assessment	DDMMYYYY	

AuSDaT ref	Question	Responses	Comment
9.160 / 9.161	Time of swallowing assessment	hh:mm; Unknown	
9.180 - 9.190	Was the swallow screen or swallowing assessment performed before the patient was given: - Oral medications - Oral food or fluids	Yes / No / Not documented	
	Hydration and nutrition		
9.220	Was malnutrition screening performed	Yes / No / Not documented	
	Mobility		
9.360	Was the patient able to walk independently on admission? (i.e. may include walking aid, but without assistance from another person)?	Yes / No / Unknown	
9.370	Was the patient mobilised in this admission?	Yes / No / Unknown	
9.380	Date of first documented mobilisation	DDMMYYYY	
9.400	Method of mobilisation documented	Sitting; Standing; Walking	
	Continence		
9.550	Was the patient assessed for urinary incontinence within 72hrs?	Yes / No / Not documented	
9.610	Was the patient incontinent of urine (or required a urinary catheter) within the first 72 hours of stroke onset?	Yes / No / Not documented	
9.660	Was a urinary incontinence management plan documented?	Yes / No / Not documented	
9.670	Did the patient have an indwelling urinary catheter within the first week of admission?	Yes / No / Not documented	
	If yes, which of the following have been documented as the reason/s for urinary catheterisation?		
9.680	Urinary retention	Yes / No	
9.690	Pre-existing catheter	Yes / No	
9.700	Urinary incontinence	Yes / No	
9.710	Need for accurate fluid balance monitoring	Yes / No	
9.720	Critical skin care	Yes / No	
9.730	No reason documented	Yes / No	

AuSDaT ref	Question	Responses	Comment
	Mood		
9.740	Was the patient's mood assessed?	Yes / No / Not documented	
9.780	If yes, did the patient have a mood impairment (depression, emotional lability, or anxiety)?	Yes / No / Not documented	
	Aphasia		
9.870	Did the patient have aphasia	Yes / No / Not documented	
	Antithrombotic therapy		
10.020	Antiplatelets given as hyperacute therapy (for ischaemic stroke or TIA)?	Yes; No; No, Other antithrombotic agent provided; Unknown; Contraindicated	
10.030	If yes, Date medication given	DDMMYYYY	
10.050 / 10.051	Time medication given	hh:mm; Unknown	
	Assessment and management of fever		
10.100	In the first 72 hours following admission did the patient develop a fever ≥ 37.5ºC	Yes / No / Not documented	
10.150	If yes, was paracetamol for the first elevated temperature administered within 1 hour	Yes; No; Already received regular paracetamol; Contraindicated; Not documented	
	Assessment and management of hyperglycaemia		
10.240	In the first 48 hours following ward admission did the patient develop a finger-prick glucose level of greater or equal 10 mmols/l?	Yes / No / Not documented	
10.250	If yes, was insulin administered within 1 hour of the first elevated finger-prick glucose (>=10 mmol/L)?	Yes / No / Not documented	
	DVT prophylaxis		
10.441	What type of DVT prophylaxis management did the patient receive?	Low molecular weight heparin; Intermittent pneumatic compression; Both; None; Contraindicated; Unknown	New question 2021
	Communication and support for patient and family/carer		
10.760	Were goals set with input from the patient and team?	Yes; No; No but met with family	
10.790	Did the patient and/or family receive information covering stroke, hospital management, secondary	Yes / No / Not documented	

AuSDaT ref	Question	Responses	Comment
	prevention and recovery (e.g. 'My Stroke Journey' booklet)?		
10.830	Does the patient have a carer?	Yes; No; Not required	
10.840	Did the carer receive relevant carer training	Yes / No	
10.841	If no, select reason	Patient transferred to inpatient rehab or other acute care; Carer declined; Other	
10.850	Did the carer receive a support needs assessment (e.g. physical, emotional and social)?	Yes / No	
10.851	If no, select reason	Patient transferred to inpatient rehab or other acute care; Carer declined; Other	
	ALLIED HEALTH MANAGEMENT		
10.450-10.490	Was the patient seen by a physiotherapist	Yes; No; Not required; Patient declined; Therapist not on staff If yes… DDMMYYYY (unknown); hh:mm (unknown)	
10.500 - 10.540	Was the patient seen by an occupational therapist	Yes; No; Not required; Patient declined; Therapist not on staff If yes… DDMMYYYY (unknown); hh:mm (unknown)	
10.550 - 10.590	Was the patient seen by a speech pathologist	Yes; No; Not required; Patient declined; Therapist not on staff If yes… DDMMYYYY (unknown); hh:mm (unknown)	
10.600 - 10.640	Was the patient seen by a social worker	Yes; No; Not required; Patient declined; Therapist not on staff If yes… DDMMYYYY (unknown); hh:mm (unknown)	
10.650-10.690	Was the patient seen by a dietitian	Yes; No; Not required; Patient declined; Therapist not on staff If yes… DDMMYYYY (unknown); hh:mm (unknown)	
10.700 - 10.740	Was the patient seen by a psychologist	Yes; No; Not required; Patient declined; Therapist not on staff If yes… DDMMYYYY (unknown); hh:mm (unknown)	
	COMPLICATIONS DURING HOSPITAL ADMISSON		

AuSDaT ref	Question	Responses	Comment
11.150	Did the patient have any of the following complications during their admission:		
11.160	Aspiration pneumonia	Yes / No	
11.170	Deep Vein Thrombosis (DVT)	Yes / No	
11.180	Falls	Yes / No	
11.190	Fever	Yes / No	
11.270	Symptomatic haemorrhagic transformation	Yes / No	
11.290	New onset atrial fibrillation	Yes / No	
11.300	New stroke	Yes / No	
11.310	Stroke progression	Yes / No	
11.320	Urinary tract infection	Yes / No	
11.330	Seizures	Yes / No	
11.370	Were any of the above complications severe (i.e. incapacitating, life threatening and prolongs hospital admission and patient acuity)?	Yes / No / Unknown	
	FURTHER REHABILITATION AND COMMUNITY RE-INTEGRATION		
12.000	Was an assessment for rehabilitation performed?	Yes / No / Unknown	
12.010	If yes, did this use the Assessment of Rehabilitation Tool?	Yes / No / Unknown	
12.020	Who undertook this assessment	Rehabilitation specialist; Rehabilitation registrar; Rehabilitation coordinator (nurse or ALH); General physician; Neurologist; Geriatrician; Other medical not specified; Acute stroke coordinator; Multidisciplinary team; Other	
12.030	Did the assessment identify the need for ongoing rehabilitation	Yes / No / Unknown	
12.040	If yes, was a referral made to rehabilitation?	Yes / No / Unknown	
12.080	If no referral was made provide reason	Return to pre-morbid function; Palliation;	

AuSDaT ref	Question	Responses	Comment
		Coma and/or unresponsive (not just drowsy); Declined rehabilitation; Plateau in function; Rehabilitation goals met; No public service available; Other	
12.090	Were they accepted for rehabilitation?	Yes / No / Unknown	
12.110 - 12.120	If no, Reason	Service full; Service cannot cope with severity; Patient/family declined; Other	
12.130	Did the patient access further rehabilitation?	Yes / No / Unknown	
12.140	If yes, Type	Inpatient rehabilitation; Outpatient rehabilitation; Community rehabilitation home based; Community rehabilitation day hospital; Early supported discharge service; Other	
	SECONDARY PREVENTION		
13.000	Is there evidence of patient education about behaviour change for modifiable risk factors prior to discharge?	Yes / No	
13.001	If no, select reason	Severe cognitive impairment; Severe communication impairment; Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway); Discharged to another hospital; Patient refused; Other	
13.011	For patients who are currently smoking or recently quit, did the patient receive smoking cessation advice (or family alone if patient has severe aphasia or cognitive impairments)?	Yes; No; Not applicable (non-smoker); Not documented	New question 2021
13.010	On discharge was the patient prescribed:		
13.020 - 13.100	Antithrombotics	Yes; No; Unknown; Contraindicated	

AuSDaT ref	Question	Responses	Comment
13.030	If yes, please specify	Aspirin; Clopidogrel; Dipyridamole MR; Other antiplatelet drug; Warfarin; Dabigatran; Rivaroxaban; Apixaban; Other anticoagulant	
13.110	If no, select reason	Patient refused; Under review; Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway); No reason given	
13.120	Antihypertensives	Yes; No; Unknown; Contraindicated	
13.200	If no, select reason	Patient refused; Under review; Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway); No reason given	
13.210	Lipid-lowering treatment	Yes; No; Unknown; Contraindicated	
13.240	If no, select reason	Patient refused; Under review; Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway); No reason given	
	DISCHARGE INFORMATION		
14.000	Patient deceased during acute care	Yes / No	
14.010	If yes, Date of death	DDMMYYYY	
14.070	Is the date of discharge known	Yes / No	
14.080	Date of discharge	DDMMYYYY	
14.15	What is the discharge diagnosis ICD10 Classification Code?	161.0 – 161.6; 161.8; 161.9; 162.9; 163.0 – 163.6; 163.8; 163.9; 164.0; G45.9; Other	

Acute Stroke Services Audit (2021)
Clinical Audit

AuSDaT ref	Question	Responses	Comment
14.160	What is the discharge destination/mode	Discharge/transfer to (an)other acute hospital; Discharge/transfer to a residential aged care service, unless this is the usual place of residence; Statistical discharge - type change; Left against medical advice/discharge at own risk; Died; Other; Usual residence (e.g. home) with supports; Usual residence (e.g. home) without supports; Inpatient rehabilitation; Transitional care services	
14.161	Please specify (if residential aged care)	Low level residential care; High level residential care	
14.190	Is there evidence that a care plan outlining post discharge care in the community was developed with the team and the patient (or family alone if patient has severe aphasia or cognitive impairments)?	Yes; No; Unknown; Not applicable (remains in hospital e.g. inpatient rehabilitation or other acute care)	
14.200 - 14.201	If yes, did this include: - Patient - Family/carer	Yes / No	
14.202	Did the patient refuse developing a care plan	Yes / No / Unknown	
14.210	Is there evidence that the general practitioner and or community providers were provided with a copy of the discharge summary?	Yes; No; Not applicable (e.g. inpatient rehab)	
14.211	If no select reason	No GP contact documented; From overseas or travelling; Other	
14.240	Did the patient receive the contact details of someone in the hospital for any post-discharge questions?	Yes; No; No but provided to family	
	Dependency on discharge		
14.250 - 14.310	Functional status prior to stroke? (mRS) Score 0-6	0-6 (derived if needed)	

*Please refer to **2021 Acute Audit Clinical Audit Data Dictionary** for more specific details on the Clinical Audit variables.