# Clinical Audit Data Dictionary

Underpinning AuSDaT and National Stroke Audit is the National Stroke Data Dictionary (NSDD), which provides standardised definitions, coding and recording guidance for all data items collected in AuSDaT. Download the full NSDD from: **http://australianstrokecoalition.com.au/ausdat/**

An episode is defined as the period of patient care between hospital admission and a formal or statistical separation, separated by only one care type. Processes of care variables should only relate to the patients' current admission at YOUR hospital.

An episode of care ends when: the patient is discharged; episode type changes; patient is transferred to another facility; or the patient dies.

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## ADMISSION AND TRANSFER INFORMATION

4.000 Onset date DD/MM/YYYY

4.030 Onset Time

| | |
|---|---|
| Definition: | Time of the current stroke or TIA, this is also known as the time the person was last seen well (i.e. if the patient awoke with symptoms of stroke or TIA the onset date is designated as the last time the patient was seen, or known to be well). |
| Values: | ▪ KWN = Known time of onset<br>▪ UNC = If uncertain time of onset, then time last seen well<br>▪ WAK = If wake up stroke, then time last seen well<br>▪ TU = Time unknown |
| Auditing Guidance: | If there are conflicting onset times, please use the following hierarchy:<br>1. Stroke team/Neurologist<br>2. Admitting physician<br>3. Emergency Department physician<br>4. ED nursing notes<br>5. Emergency medical staff/Ambulance reports<br>If stroke onset time is unclear, then time last seen well should be recorded. In this circumstance enter the time the patient was last seen well and identify as “if uncertain time of stroke, then time last seen well”. |

4.140 Did the stroke occur while the patient was in hospital? (Yes / No / Unknown)

4.150 Date of arrival to emergency department DD/MM/YYYY

4.170 Time of arrival to emergency department

4.200 Did the patient arrive by ambulance? (Yes / No / Unknown)

4.220 Was the patient transferred from another hospital? (Yes / No / Unknown)

| | |
|---|---|
| Definition: | Inter-hospital transfer. Patient transported directly from one hospital to another, for admission for acute stroke/TIA management. |
| Auditing Guidance: | Transfer includes from other hospitals intrastate, interstate and internationally. A patient is considered to be an interhospital transfer irrespective of whether they are transported directly to a ward bed or admitted following initial management in the Emergency Department within the receiving hospital.<br>As a guide, the median length of stay of a hospital admission for acute stroke management has been found to be four days (Cadilhac et al. (2015), 'Australian Stroke Clinical Registry: 2014 Annual Report').<br>This does not apply to patients who are being admitted for non-acute medical care (i.e. for stroke rehabilitation or awaiting placement in transition or residential aged care).<br>If there is conflicting information about whether the patient was transferred from another hospital select "Unknown". |

4.230 Was the patient transferred to another hospital for acute care after admission to your hospital? (Yes / No)

| | |
|---|---|
| Definition: | Transfer to another hospital for further acute care |
| Auditing Guidance: | Transfer of care must be for acute care only rather than awaiting placement or rehabilitation. Transfer includes from hospitals intrastate, interstate and internationally. |

4.240 Date of transfer DD/MM/YYYY

4.260 Time of transfer

4.290 Date of admission to hospital DD/MM/YYYY

4.320 Time of admission to hospital

4.360 What was the ward for initial admission?

| | |
|---|---|
| Definition: | First ward to which the patient was admitted. |
| Values: | ▪ SU = Stroke unit<br>▪ NEU = Other neuroscience ward<br>▪ MW = Medical ward<br>▪ SW = Surgical ward<br>▪ MSW = Mixed med/surgical ward<br>▪ RW = Rehabilitation ward<br>▪ ICU = ICU<br>▪ UNK = Unknown<br>▪ OTH = Other |

4.380 Was the patient treated in a stroke unit at any time during their stay? (Yes / No / Unknown)

| Definition: | Patient admitted to a Stroke Unit at some stage during their acute episode of care. |
|---|---|
| Auditing Guidance: | The National Acute Stroke Services Framework 2015, defines the minimum criteria for a stroke unit as:<br>• Co-located beds within a geographically defined unit.<br>• Dedicated, interprofessional team with members who have a special interest in stroke and/or rehabilitation. The minimum team would consist of medical, nursing and allied health (including Occupational Therapy, Physiotherapy, Speech Pathology, Social Worker and Dietitian).<br>• Interdisciplinary team meets at least once per week to discuss patient care.<br>• Regular programs of staff education and training relating to stroke (e.g. dedicated stroke inservice program and/or access to annual national or regional stroke conference).<br>Co-located beds within a geographically defined unit include where beds are within the one room/bay or in rooms that are side by side but as a minimum can mean beds within the SAME ward (i.e. not just in the same room) as long as the same inter-professional team manage people with stroke. |

4.390 If yes, date of admission to stroke unit DD/MM/YYYY

4.400 If yes, time of admission to stroke unit

4.420 If yes, date of discharge from stroke unit DD/MM/YYYY

## PRE STROKE HISTORY

6.000 Did the patient have any history of known risk factors prior to admission?

6.010 Atrial Fibrillation (Yes / No / Unknown)

| Auditing Guidance: | Select “Yes” if the patient is in persistent, permanent or paroxysmal atrial fibrillation PRIOR to this admission. |
|---|---|

6.020 Previous Stroke (Yes / No / Unknown)

| Auditing Guidance: | Select “Yes” if there is a history of stroke, probable stroke, or history consistent with stroke PRIOR to this admission.<br>This may be described verbally by the patient, or documented in previous medical notes or confirmed on brain imaging. |
|---|---|

6.050 Previous TIA (Yes / No / Unknown)

| Auditing Guidance: | Select "Yes" if documented evidence of a previous TIA PRIOR to this admission, and/or if documented as Amaurosis fugax. |
|---|---|

6.120 Ischaemic heart disease (Yes / No / Unknown)

| Auditing Guidance: | Select "Yes" if Ischaemic heart disease includes any history of a heart attack or angina PRIOR to this admission. |
|---|---|

6.180 Dementia (Yes / No / Unknown)

| Auditing Guidance: | Select "Yes" if the patient has chronic or persistent loss of global cognitive ability PRIOR to this admission. |
|---|---|

**Dependency prior to admission**

6.470 Functional status prior to stroke? (mRS) Score 0-5

| Definition: | Patient's modified Rankin scale score (0-5) prior to stroke |
|---|---|
| Values: | Numerical 0-5 |
| Auditing Guidance: | If mRS is known, enter one number, 0-5<br>0: No symptoms at all<br>1: No significant disability despite symptoms; able to carry out all usual duties and activities<br>2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance<br>3: Moderate disability; requiring some help, but able to walk without assistance<br>4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance<br>5: Severe disability; bedridden, incontinent, and requiring constant nursing care and attention<br><br>mRS training is available at: http://rankin-english.trainingcampus.net/uas/modules/trees/windex.aspx<br>If two options appear equally valid and if further questions are considered unlikely to clarify choice, then the more severe category should be selected.<br><br>The modified Rankin Scale (mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke, and it has become the most widely used clinical outcome measure for stroke clinical trials. Independence= 0-2, dependence >=3. |

6.540 Living arrangements prior to admission?

| Definition: | Patient's living arrangements before having this stroke. |
|---|---|
| Values: | ▪ 1 = Home (alone)<br>▪ 2 = Home (with others)<br>▪ 3 = Supported accommodation e.g. nursing home, hostel<br>▪ 9 = Other |
| Auditing Guidance: | Home means any private residence, including family or friends.<br>Other might include welfare institutions, prisons and group homes. |

## 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?

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? DD/MM/YYYY

7.440 Time of first brain scan after the stroke?

7.460 What type of brain scan was performed? (CT / MRI / BOTH CT & MRI)

| Definition: | Type of brain imaging technique used |
|---|---|
| Auditing Guidance: | Performance of brain imaging (Computerised Tomography – CT, or Magnetic Resonance Imaging - MRI) after this episode of stroke. |

7.470 Was advanced imagining performed (Yes / No)

7.471 CT angiography (Yes / No)

7.472 CT perfusion (Yes / No)

| Auditing Guidance: | Advanced imaging refers to CTA angiography +/- CTP perfusion, undertaken to determine infarct volume and can guide further interventions (e.g. endovascular therapy).<br>Advanced MRI and CT imaging techniques may be used to identify ischaemic but potentially viable brain tissue and thus guide intervention decisions in the hyper-acute phase. |
|---|---|

7.550 Type of stroke (TIA / Ischaemic / Haemorrhage / Undetermined)

| Auditing Guidance: | This is not the ICD-10-AM code, but rather the clinical diagnosis.<br>"TIA" should be selected if the patient's definitive or probable diagnosis at the time of discharge from hospital is compatible with a TIA (symptoms/neurological deficits persisted < 24 hours of onset; normal neuroimaging).<br>"Ischaemic" stroke type should be selected if the brain imaging is consistent with cortical, sub-cortical, brainstem or cerebellar infarction.<br>"Haemorrhage" stroke type should be selected if the brain imagining is consistent with intraventricular, intracerebral haemorrhage (ICH) or other non-traumatic intracerebral haemorrhage.<br>"Undetermined" stroke type should be selected if the brain imaging report is inconclusive or if no brain imaging has been undertaken and the stroke type cannot be confirmed through other diagnostic assessments. |
|---|---|

**Other investigations**

7.670 Did the patient have an investigation of the carotid arteries while in hospital? (Yes / No)

| Definition: | Performance of any diagnostic investigation that can identify carotid artery stenosis while patient was in hospital |
|---|---|
| Auditing Guidance: | Carotid stenosis is usually diagnosed by colour flow duplex ultrasound scan of the carotid arteries in the neck.<br>Typically duplex ultrasound scan is the only investigation required for decision making (including proceeding to intervention) in carotid stenosis.<br>Occasionally further imaging is required. One of several different imaging modalities, such as angiogram, computed tomography angiogram (CTA) or magnetic resonance imaging angiogram (MRA) may be useful.<br>Each imaging modality has its advantages and disadvantages - the investigation chosen will depend on the clinical question and the imaging expertise, experience and equipment available. |

## TELEMEDICINE AND REPERFUSION

8.120 Was the patient screened for eligibility for intravenous thrombolysis (Yes / No)

| Auditing Guidance: | This would generally involve documentation that stroke time of onset was reviewed and accurately determined, that an acute stroke physician or nurse undertook a clinical assessment and an NIHSS score was performed, plus that an urgent CT scan of the brain was performed, and that ICH was excluded. There are screening tools also such as the ED care bundle and there is work underway in TIPS and T3 in this area.<br>Intravenous thrombolysis in acute ischaemic stroke should only be undertaken in patients satisfying specific inclusion and exclusion criteria. Thrombolysis should only be given under the authority of a physician trained and experienced in acute stroke management and only in a hospital setting with appropriate infrastructure, facilities, and network support. |
|---|---|

8.130 Did the patient receive intravenous thrombolysis (Yes / No / Unknown)

| Auditing Guidance: | Select "Yes" if there is documentation that the patient, admitted with an ischaemic stroke, received thrombolytic therapy. This is regardless of whether they receive intravenous or intraarterial thrombolysis.<br>Select "No" if there is no documentation that patient, admitted with an ischaemic stroke, received thrombolytic therapy.<br>Select "Unknown" if it cannot be determined whether thrombolytic therapy was provided e.g., unable to location relevant medication chart.<br>If initiated by a bolus dose whether in a pre-hospital setting i.e., transfer from another hospital (emergency department or inpatient unit/ward), irrespective of whether they received intravenous or intra-arterial thrombolysis, then record "Yes" for "Did the patient receive thrombolysis".<br>Do not include thrombolytic therapy for indications other than ischaemic stroke i.e., include intra-cerebral venous infusion for cerebral venous thrombosis, intraventricular infusion for intraventricular haemorrhage, intraparenchymal infusion for percutaneous aspiration of intracerebral haematoma, myocardial infarction, pulmonary embolism, or peripheral clot. |
|---|---|

8.140 If Yes, date of delivery? DD/MM/YYYY

8.150 If Yes, time of delivery?

## OTHER CLINICAL INFORMATION

**Impairments on admission**

On admission were any of the following impairments present?

9.000 Sensory deficit (Yes / No / Not documented)

| Auditing Guidance: | Any impairment of the sensory system. |
|---|---|

9.010 Cognitive deficit (Yes / No / Not documented)

| Auditing Guidance: | Any impairment of memory or higher executive functions including but not limited to aphasia, acalculia, dysgraphia, left-right disorientation, finger agnosia. |
|---|---|

9.020 Visual deficit (Yes / No)

| Auditing Guidance: | Any deficit of the visual fields. |
|---|---|

9.030 Perceptual deficit (Yes / No / Not documented)

| Auditing Guidance: | Any deficit of perception. |
|---|---|

9.040 Speech/communication impairment (Yes / No / Not documented)

| Auditing Guidance: | Any form of expressive or receptive dysphasia or aphasia, verbal dyspraxia, or dysarthria. |
|---|---|

9.050 Hydration problems (Yes / No / Not documented)

| Auditing Guidance: | If an assessment of the patient's fluid status suggests they are dehydrated, then this should be marked. |
|---|---|

9.060 Nutrition problems (Yes / No/ Not documented)

| Auditing Guidance: | If there is a note in the admission note suggesting that they are or are suspected of suffering from nutritional disorder, then this should be marked. |
|---|---|

9.061 Arm deficit (Yes / No / Not documented)

| Auditing Guidance: | Difficulty moving any part of the arm specifically due to the stroke i.e., hand, elbow, and/or shoulder. |
|---|---|

9.062 Lower limb deficit (Yes / No / Not documented)

| Auditing Guidance: | Difficulty moving any part of the leg specifically due to the stroke i.e., foot, knee, or hip. |
|---|---|

9.063 Dysphagia (Yes / No / Not documented)

| Auditing Guidance: | Any difficulty in swallowing function. |
|---|---|

9.064 Continence (Yes / No / Not documented)

| Auditing Guidance: | Impairment of urinary and/or bowel functions. |
|---|---|

9.065 Balance (Yes / No / Not documented)

| Auditing Guidance: | Impaired ability in balance either while sitting, standing, or walking. |
|---|---|

9.066 Other (Yes / No / Not documented)

| Definition: | Presence of an impairments on admission not mentioned in this list. |
|---|---|

**Swallowing**

9.070 Was a formal swallowing screen performed (e.g., not a test of gag reflex)? (Yes / No / Not documented)

| Definition: | Swallow screen conducted by an appropriately trained health care professional such as a nurse or doctor utilising a formal swallow screen tool. |
|---|---|
| Auditing Guidance: | Select "Yes" if there is documented evidence of a patient receiving a swallow screen by an appropriately trained healthcare professional.<br><br>If the patient has an impaired level of consciousness (or is unconscious) and is unable to participate in a swallow screen, select "Yes" only if they are documented as "Nil orally". A swallow screen/assessment should be performed when the patient is able to participate prior to being given any food, drink, or oral medications.<br><br>The formal swallow screen tool is only performed by non-Speech Pathology Healthcare Professionals. For Speech Pathology assessment data refer to the MDL References: 9.130, 9.140, 9.150, 9.160, 9.161, and 9.170.<br><br>Select "Yes" if the patient had both a formal swallow screen regardless of whether a Speech Pathology assessment. |

9.080 Date of screening DD/MM/YYYY 9.080 Time of screening

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? DD/MM/YYYY 9.140 Time of swallowing assessment?

9.180 Was the swallow screen or swallowing assessment performed before the patient was given:

- Oral medications (Yes / No / Not documented)

- Oral food or fluids (Yes / No / Not documented)

| | |
|---|---|
| Definition: | Swallow screen by a trained health professional or swallow assessment completed by a speech pathologist conducted prior to patient receiving any form of oral intake, this includes medication, food or fluids. |
| Auditing Guidance: | Select "Yes" if the patient did not receive any form of oral intake (medications, food, or fluids) prior to having a formal swallow screen by an appropriately trained health care professional and/or formal swallow assessment by a speech pathologist.<br><br>Select "No" if the patient received oral intake (medications, food, and fluids) prior to having a formal swallow screen by an appropriately trained healthcare professional and/or formal swallow assessment conducted by a speech pathologist.<br><br>Select "Not documented" if there is no documented. |

**Hydration and nutrition**

9.220 Was malnutrition screening performed? (Yes / No / Not documented)

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|---|---|
| Definition: | Evidence that a validated tool was used to screen the patient for malnutrition. |
| Auditing Guidance: | Screening should be undertaken using a validated nutrition screening tool e.g. Malnutrition Universal Screening Tool (MUST) or the Malnutrition Screening Tool (MST).<br><br>BMI (Body Mass Index) is not a validated malnutrition screening tool, because it does not indicate if the patient is at risk of malnutrition.<br><br>A screen can be performed by any trained medical or allied health staff member with appropriate skills and training in the completion of the screening tool used in their unit.<br><br>This is a separate measure to a nutrition assessment. The two should not be confused. |

**Mobilisation**

9.360 Was the patient able to walk independently on admission? (Yes / No / Unknown)

| | |
|---|---|
| Definition: | Ability to walk unaided or without any form of assistance, at the time of arrival.<br>This variable is used as a measure for stroke severity and is a global measure of disability that is normally assessed at the time of admission to hospital. |
| Auditing Guidance: | Select "Yes" if patient able to walk independently or with supervision irrespective of use of gait aid, but without assistance of another person, at time of arrival.<br><br>Examples of independent mobility:<br>▪ Patient walked independently (no equipment, no help from another person)<br>▪ Patient walked with assistance from an assistive device (e.g., walking stick or frame)<br>▪ Patient walked to and from bathroom<br>▪ Patient received supervision<br>Examples of not being able to mobilise independently:<br>▪ Patient needed assistance from another person/s to walk<br>▪ Patient used a wheelchair or bed trolley<br>▪ Patient is only getting out of bed to the bedside commode (or up in chair)<br>Select "No" if patient has a modified Rankin Score of 4 or 5. |

9.370 Was the patient mobilised in the admission? (Yes / No / Unknown)

9.380 Date of first documented mobilisation DD/MM/YYYY

9.400 Method of mobilisation documented (Sitting / Standing / Walking)

| | |
|---|---|
| Definition: | Type of first mobilisation made during the patient's acute admission, after stroke onset. |
| Auditing Guidance: | Mobilisation includes sitting on edge of the bed, sitting out in a chair, standing or walking regardless of level of independence with mobilisation i.e., whether they were able to complete type of mobilisation independently or required assistance. The type of mobilisation refers to independent and assisted methods.<br><br>If the patient mobilised during their acute admission, following their stroke, select the type of mobilisation first documented within the patient's notes following arrival at your hospital.<br><br>If, during their first mobilisation post stroke, they use more than one type of mobilisation, the following hierarchy applies (walking then standing, then sitting). For instance, if a patient transferred from bed and walked to bathroom select "Walking". |

| | |
|---|---|
| | If the patient is assisted to sit on the edge of bed, assisted out of bed, patslid out of bed or alternatively hoisted out of bed then select "Sitting" as the type of mobilisation.<br><br>For in-hospital strokes or TIA's i.e., patient has a stroke or TIA during an acute episode of admitted care for a different condition then select the type of mobilisation first documented within the patient's notes, following onset of stroke or TIA symptoms.<br><br>For inter-hospital transfers select the type of mobilisation first documented in the patient's notes following arrival at YOUR hospital.<br><br>In circumstances where the patient is admitted with a stroke or TIA and has a subsequent stroke during the same acute episode of care, select the type of mobilisation first documented following the initial stroke in relation to the same episode of admitted care |

**Continence**

9.550 Was the patient assessed for urinary incontinence within 72hrs? (Yes / No / Not documented)

| | |
|---|---|
| Definition: | Documented evidence that the patient was assessed for urinary incontinence within 72 hours of arrival at ED i.e. dysfunction of the bladder in which the patient has had an involuntary loss of urine. |
| Auditing Guidance: | Urinary incontinence may have been present prior to stroke but assessment of bladder function should still occur in all patients with stroke within 72 hours.<br><br>Any assessment (clinical history, validated scales, physical examination, simple or advanced investigations including bladder scan) constitutes a "Yes" if documented to have occurred within 72 hours of stroke onset arrival to ED (rather than admission to ward).<br><br>Check observation chart and patient notes.<br><br>Urinary incontinence is a predictor of poorer outcomes after stroke. |

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)

| | |
|---|---|
| Auditing Guidance: | Answer "Yes" if within the first 72 hours of stroke care, urinary incontinence was identified/confirmed and/or if urinary catheter is used. This includes all types of urinary incontinence (urge, retention, functional). |

9.660 Was a urinary incontinence management plan documented? (Yes / No / Not documented)

| Auditing Guidance: | The minimum content criteria are:<br>(i) documentation of a specific care plan addressing urinary incontinence;<br>(ii) a provisional diagnosis of the cause of the urinary incontinence; and<br>(iii) other evidence of interventions to avoid complications and promote continence.<br><br>Compliance requires documentary evidence as either part of a structured ward-based tool or is evidenced by documentation in the medical records of a plan to "actively" manage/treat incontinence (such as in-out catheters, 2 hourly panning) or prevent complications (appropriate positioning of the patient, regular pressure care, etc).<br>The plan should be consistent with current evidence-based guidelines or protocols. |
|---|---|

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)

**Mood**

9.740 Was the patient's mood assessed? (Yes / No / Not documented)

| Definition: | Evidence that patient's mood (state of mind or emotion) was assessed during this admission. Depression, anxiety and emotional lability are common after stroke and should be assessed and treated. Mood assessment tools include Geriatric Depression Scale= GDS, Hospital and Depression Scale= HADS, etc. |
|---|---|

9.780 Did the patient have a mood impairment (depression, emotional lability, or anxiety)? (Yes / No / Not documented)

| Definition: | Evidence that patient had any form of mood disturbance e.g. depression, emotional lability or anxiety. |
|---|---|

**Aphasia**

9.870 Did the patient have aphasia? (Yes / No / Not documented)

| Definition: | Evidence that patient had aphasia, a common communication deficit following stroke. |
|---|---|
| Auditing Guidance: | Aphasia is an impairment of language, affecting the production or comprehension of speech, and the ability to read or write.<br><br>Look for evidence of assessment from a speech pathologist – particularly assessment findings and look for documentation from medical, nursing, and allied health regarding communication issues. |

**Antithrombotic therapy**

10.020 Antiplatelets given as hyperacute therapy (for ischaemic stroke or TIA)?

| Definition: | Antiplatelets or anticoagulent agent administered as hyperacute therapy for ischaemic stroke or TIA as early as possible in the first 48 hours of their stroke symptoms/stroke onset. |
|---|---|
| Values: | ▪ 1 = Yes<br>▪ 2 = No<br>▪ 0 = No, but anticoagulent agent provided<br>▪ U = Unknown<br>▪ CI = Contraindicated |
| Auditing Guidance: | This field is relevant to ischaemic stroke and TIA only. Where stroke type is intracerebral haemorrhage (ICH), select Contraindicated.<br><br>Select Yes if the patient was administered an antiplatelet such as aspirin, clopidogrel, combined aspirin and dipyridamole, or combined aspirin and clopidogrel within 48 hours of stroke onset at your hospital during the current episode of care.<br><br>Select No if the person was administered an antiplatelet or anticoagulant prior to presentation at your hospital.<br><br>Select No, but anticoagulant agent provided if an anticoagulant agent was provided within 48 hours of stroke onset, such as a direct oral anticoagulant (DOAC) or warfarin. |

| | |
|---|---|
| | Select Unknown if unable to locate medication chart or the date and time on the medication chart is not clear.<br><br>Select Contraindicated if stroke type is ICH, or if antiplatelet therapy is contraindicated for another reason.<br><br>Provision of thrombolysis should not be considered as a contraindication more than 24 hours after provision and where a subsequent brain scan has excluded haemorrhage. |

10.030 If yes, date medication given DD/MM/YYYY 10.050 Time medication given

| | |
|---|---|
| Definition: | The date (and accuracy) that the antiplatelets was first administered as hyperacute therapy for ischaemic stroke or TIA. Hyperacute therapy refers to the provision of medication during the first 48 hours of their stroke symptoms/ stroke onset. |

**Assessment and management of fever**

10.100 In the first 72 hours following admission did the patient develop a fever ≥ 37.5C? (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 than 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?

| | |
|---|---|
| Definition | Management strategy used for DVT prophylaxis |
| Main Source of Standard | Definition Attributes:<br>Stroke Foundation. Clinical Guidelines for Stroke Management 2017. |
| Codes and Values | Answer options:<br>Low molecular weight heparin |

| | |
|---|---|
| | Intermittent pneumatic compression<br>Both<br>None<br>Contraindicated<br>Unknown |
| Help Notes | Heparin based prophylaxis is contraindicated for those with a recent systemic bleeding tendency (e.g. recent gastrointestinal haemorrhage) or current intracranial haemorrhage (e.g. haemorrhagic stroke and ischaemic stroke with haemorrhagic transformation).<br>Caution is required for those with low platelet count.<br>Physical methods may be contraindicated for those with peripheral vascular disease (symptomatic, or those with absent lower limb pulses).<br>Further anticoagulation is not indicated if the patient is already on an oral anticoagulant, except in very high-risk situations. |
| Further Information | Most hospitals have a DVT policy and so local policies should be consulted. |

**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)

| | |
|---|---|
| Definition: | Evidence that goals were set within input from both the patient and the multidisciplinary team. |
| Auditing Guidance: | Goal setting must have involved both the patient and the multidisciplinary team.<br><br>If the patient was not consulted for the goal-setting process then a “no” response is mandated, unless the patient was unable to communicate because of aphasia or cognitive impairment that prohibited active participation in goal setting. In this instance, if the family/carer were involved in goal setting with the team then “No, but met with family” is the most appropriate response. |

10.790 Did the patient and/or family receive information covering stroke, hospital management, secondary prevention and recovery (e.g. 'My Stroke Journey' booklet)? (Yes / No / Not documented)

| | |
|---|---|
| Definition: | Evidence that information covering stroke, hospital management, secondary prevention and recovery was provided to patient and/or family. |
| Auditing Guidance: | Look for evidence that routine information (such as the ‘My Stroke Journey’ booklet, or locally developed information pack) was provided to the patient and/or family. |

| | |
|---|---|
| | This information normally includes general information about stroke, hospital management including secondary prevention. Additional tailored information may also be included. |

10.830 Does the patient have a carer? (Yes / No / Not required)

| | |
|---|---|
| Definition: | Evidence that patient has a carer e.g. an individual that assists the stroke survivor with day to day activities without whom they would not be able to cope at home. |
| Auditing Guidance: | Look for documented evidence that an individual would assume responsibility for care of the stroke survivor following discharge.<br><br>A spouse or housemate is only classed as a "carer" if they provide care.<br><br>An individual who helps the patient with everyday tasks which could include but not limited to, washing, dressing, and cooking. |

10.840 Did the carer receive relevant carer training (Yes / No)

| | |
|---|---|
| Definition: | Training provided to the patient's carer on specific needs the patients will have when returning home. |
| Auditing Guidance: | Look for written evidence that the carer was trained in methods relevant to care in the community e.g. transfers, pressure care etc. |

10.841 If no, select reason

| | |
|---|---|
| Definition: | Reason carer did not receive relevant training |
| Auditing Guidance: | 1 = Patient transferred to inpatient rehab or other acute care<br>2 = Carer declined<br>3 = Other |

10.850 Did the carer receive a support needs assessment (e.g. physical, emotional, etc.)? (Yes / No)

| | |
|---|---|
| Definition: | Written evidence of a discussion between the carer and the multidisciplinary team about their emotional, physical, social, financial needs prior to the discharge of the person with stroke to their care. |
| Auditing Guidance: | The carers need for support will be complex as they may have to make considerable lifestyle adjustment (with employment, lifestyle, financial, and psychological consequences). |

10.851 If no, select reason

| Definition: | Reason carer did not receive support needs assessment |
|---|---|
| Auditing Guidance: | 1 = Patient transferred to inpatient rehab or other acute care<br>2 = Carer declined<br>3 = Other |

## ALLIED HEALTH MANAGEMENT

10.450 Was the patient seen by a physiotherapist? (Yes / No / Patient declined / Therapist not on staff)

| Definition: | First assessment by a physiotherapist |
|---|---|
| Auditing Guidance: | "Therapist not on staff" is only to be selected when your site does not employ this discipline. It is not to be selected if the therapist exists but was on leave or unavailable that day. |

10.460 Date DD/MM/YYYY 10.470 Unknown

| Definition: | Date of first physiotherapist assessment |
|---|---|
| Auditing Guidance: | Answer "Unknown" if date of assessment not documented in patient notes. |

10.500 Was the patient seen by an occupational therapist? (Yes / No / Not required / Therapist not on staff)

| Definition: | First assessment by an occupational therapist |
|---|---|
| Auditing Guidance: | Not required applies if it was not deemed necessary for this patient to be assessed by this therapeutic discipline. (please indicate in the comments box why you have selected "Not required").<br><br>Therapist not available on staff is only to be selected when your site does not employ this discipline. It is not to be selected if the therapist exists but was on leave or unavailable that day. |

10.510 Date DD/MM/YYYY 10.520 Unknown

| Definition: | Date of occupational therapist assessment |
|---|---|
| Auditing Guidance: | Answer "Unknown" if date of assessment not documented in patient notes. |

10.550 Was the patient seen by a speech pathologist? (Yes / No / Not required / Therapist not on staff)

| Definition: | First assessment by Speech Pathologist |
|---|---|
| Auditing Guidance: | Not required applies if it was not deemed necessary for this patient to be assessed by this therapeutic discipline. (please indicate in the comments box why you have selected "Not required").<br><br>Therapist not available on staff is only to be selected when your site does not employ this discipline. It is not to be selected if the therapist exists but was on leave or unavailable that day. |

10.560 Date DD/MM/YYYY 10.570 Unknown

| Definition: | Date of first speech and language therapist assessment. |
|---|---|
| Auditing Guidance: | Answer "Unknown" if date of assessment not documented in patient notes. |

10.600 Was the patient seen by a social worker? (Yes / No / Not required / Therapist not on staff)

| Definition: | First assessment by social worker. |
|---|---|
| Auditing Guidance: | "Not required" applies if it was not deemed necessary for this patient to be assessed by this therapeutic discipline. (please indicate in the comments box why you have selected "not required").<br><br>Therapist not available on staff is only to be selected when your site does not employ this discipline. It is not to be selected if the therapist exists but was on leave or unavailable that day. |

10.610 Date DD/MM/YYYY 10.620 Unknown

| Definition: | Date was first seen by social worker. |
|---|---|
| Auditing Guidance: | Answer "Unknown" if date of assessment not documented in patient notes. |

10.650 Was the patient seen by a dietitian? (Yes / No / Not required / Therapist not on staff)

| Definition: | First assessment by a dietitian. |
|---|---|
| Auditing Guidance: | "Not required" applies if it was not deemed necessary for this patient to be assessed by this therapeutic discipline. (please indicate in the comments box why you have selected "Not required"). |

| | |
|---|---|
| | Therapist not available on staff is only to be selected when your site does not employ this discipline. It is not to be selected if the therapist exists but was on leave or unavailable that day. |

10.660 Date DD/MM/YYYY 10.670 Unknown

| | |
|---|---|
| Definition: | Date was first seen by dietitian. |
| Auditing Guidance: | Answer "Unknown" if date of assessment not documented in patient notes. |

10.700 Was the patient seen by a psychologist? (Yes / No / Not required / Therapist not on staff)

| | |
|---|---|
| Definition: | First assessment by a psychologist. |
| Auditing Guidance: | "Not required" applies if it wasn't deemed necessary for this patient to be assessed by this therapeutic discipline. (please indicate in the comments box why you have selected "Not required").<br><br>"Therapist not available on staff" is only to be selected when your site does not employ this particular discipline. It is not to be selected if the therapist exists but was on leave or unavailable that day. |

10.730 Date DD/MM/YYYY 10.740 Unknown

| | |
|---|---|
| Definition: | Date was first seen by a psychologist. |
| Auditing Guidance: | Answer "Unknown" if date of assessment not documented in patient notes. |

## COMPLICATION DURING HOSPITAL ADMISSIONS

Did the patient have any of the following complications during their admission?

11.160 Aspiration pneumonia (Yes / No)

| | |
|---|---|
| Auditing Guidance: | A working diagnosis of aspiration pneumonia is sufficient to tick "Yes". |

11.170 Deep Vein Thrombosis (DVT) (Yes / No)

| | |
|---|---|
| Auditing Guidance: | Deep Vein Thrombosis (DVT) - Noted in the medical notes and proven on venous doppler and/or commenced on treatment (heparin, warfarin, LMW Heparin or IVC filter etc). Please note that doses for DVT prophylaxis are significantly lower than those used for treatment of DVT. |

11.180 Falls (Yes / No)

| | |
|---|---|
| Auditing Guidance: | Any fall in hospital. |

11.190 Fever (Yes / No)

| | |
|---|---|
| Auditing Guidance: | Two recorded temps above 38.5 in the first few days. |

11.270 Symptomatic haemorrhagic transformation (Yes / No)

| | |
|---|---|
| Auditing Guidance: | Refers to bleeding that causes clinical deterioration as identified with a scan rather than a scan that shows a bleed without clinical sequelae. |

11.290 NEW onset atrial fibrillation (Yes / No)

| | |
|---|---|
| Auditing Guidance: | Atrial fibrillation is usually written as the abbreviation AF. Heartbeats do not occur at regular intervals. A strong indicator of AF is the absence of P waves on an electrocardiogram (ECG). |

11.300 NEW stroke (Yes / No)

| | |
|---|---|
| Auditing Guidance: | New clinical stroke, focal neurological symptoms lasting greater than 24 hrs. Most likely to be in a different area of the brain with new symptoms. |

11.310 Stroke progression (Yes / No)

| | |
|---|---|
| Auditing Guidance: | A working diagnosis of stroke progression is sufficient to tick Yes with or without imaging confirmation. These symptoms will be in the same territory (but could be worsening) as the original stroke. |

11.320 Urinary tract infection (Yes / No)

| Auditing Guidance: | Use MSU result or patient started antibiotics commonly used for UTI's (Augmentin, Bactrim) as a "Yes". |
|---|---|

11.330 Seizures (Yes / No)

| Auditing Guidance: | Bouts of disorganized electrical activity in the brain. |
|---|---|

11.370 Were any of the above complications severe (i.e., incapacitating, life threatening, prolongs hospital admission, patient acuity? (Yes / No / Unknown)

## FURTHER REHABILITATION AND COMMUNITY RE-INTEGRATION

12.000 Was an assessment for rehabilitation performed? (Yes / No / Unknown)

| Definition: | Performance of a formal assessment for rehabilitation to determine the patient's rehabilitation needs and the optimal way to meet these needs. |
|---|---|
| Auditing Guidance: | Review if any documented assessment for ongoing rehabilitation. This may be found as part of the case conference notes or outcomes of any assessment for further rehabilitation by one of the team (or rehabilitation service staff). |

12.010 If yes, did this use the Assessment of Rehabilitation Tool? (Yes / No / Unknown)

| Auditing Guidance: | Question enabled if "Yes" answered for "Was an assessment for rehabilitation performed?" (Ref 12.000).<br>Look for documented evidence of the use of the Assessment of Rehabilitation Decision Making Tool as developed by the Australian Stroke Coalition (ASC) Rehabilitation Working Group.<br>This tool outlines specific aspects of care to consider and lists 4 possible exclusions which may also be documented (return to pre-morbid function, receiving palliative care, in a coma and/or unresponsive, declined rehab).<br>http://australianstrokecoalition.com.au/site/media/ASC-Assessment-for-Rehabilitation-Manual-and-Decision-Making-Tool-final2.pdf |
|---|---|

12.020 Who undertook this assessment?

| Definition: | Specialty of health professional who undertook the rehabilitation assessment (if the Ax rehab tool was not used). |
|---|---|
| Values: | RS = Rehabilitation specialist<br>RR = Rehabilitation registrar<br>RC = Rehabilitation coordinator (nurse or ALH) |

| | |
|---|---|
| | GP = General physician<br>NE = Neurologist<br>GE = Geriatrician<br>OM = Other medical not specified<br>ASC = Acute stroke coordinator<br>MDT = Multidisciplinary team<br>OTH = other |

12.030 Did the assessment identify the need for ongoing rehabilitation? (Yes / No / Unknown)

| Definition: | Identification of patient need for ongoing rehabilitation as a result of the rehabilitation assessment. |
|---|---|

12.040 If yes, was a referral made to rehabilitation? (Yes / No / Unknown)

| Definition: | Evidence that patient was referred to rehabilitation services. |
|---|---|

12.080 If no referral was made provide reason?

| Definition: | Reason why the patient was not referred for rehabilitation. |
|---|---|
| Values: | RPF = Return to pre-morbid function<br>PAL = Palliation<br>COU = Coma and/or unresponsive (not just drowsy)<br>DRH = Declined rehabilitation<br>PIF = Plateau in function<br>RGM = Rehabilitation goals met<br>NSA = No public service available<br>OTH = Other |

12.090 Were they accepted for rehabilitation? (Yes / No / Unknown)

| Definition: | Evidence that patient was accepted for rehabilitation. |
|---|---|

12.110 If no, Reason?

| Definition: | Reason why patient was not accepted for rehabilitation. |
|---|---|
| Values: | SF = Service full<br>SS = Service cannot cope with severity<br>PD = Patient/family declined |

| | |
|---|---|
| | OTH = Other (details not required) |

12.130 Did the patient access further rehabilitation? (Yes / No / Unknown)

| | |
|---|---|
| Definition: | Evidence that patient accessed the rehabilitation referred/accepted to.<br>Actual rehabilitation provision must be documented (rather than just referral to). |

12.140 If yes, Type:

| | |
|---|---|
| Definition: | Type of further rehabilitation accessed by patient |
| Values: | IR = Inpatient rehabilitation<br>OR = Outpatient rehabilitation<br>CRH = Community rehabilitation home based<br>CRD = Community rehabilitation day hospital<br>ESD = Early supported discharge service<br>OTH = Other |
| Auditing Guidance: | Select the location where rehab will be delivered. If not listed, select “Other” and provide details.<br><br>Inpatient rehabilitation - includes care within a hospital setting (either on a mixed rehabilitation unit, a comprehensive stroke unit, or a stroke rehabilitation unit).<br><br>Outpatient rehabilitation - is a form of community (ambulatory care) based rehabilitation which involves the patient attending appointments (individual or in a group) within a clinic or outpatient setting.<br><br>Community home based rehabilitation - includes services that provide therapy within a home setting (sometimes referred to ‘Rehabilitation In The Home’ [RITH]). This service is accessed after inpatient rehabilitation (and so not to be confused with ESD). May be described as a transitional care service if active rehabilitation is provided.<br><br>Community rehabilitation day hospital - involves the patient receiving rehabilitation via day hospital setting.<br><br>Early Supported Discharge (ESD) - service is a service that aims to allow early discharge from hospital but provide similar intensity and care within patient’s home. This service replaces inpatient rehabilitation services. It is not simply transitional care services (unless there is full multidisciplinary team with higher intensity). |

## SECONDARY PREVENTION

13.000 Is there evidence of patient education about behaviour change for modifiable risk factors prior to discharge? (Yes / No)

| | |
|---|---|
| Definition: | Evidence that patient was provided with information about behaviour change for modifiable risk factors (lifestyle and medication adherence) prior to discharge. |
| Auditing Guidance: | There needs to be written evidence in the patient's record that a discussion has occurred and/or tailored written information provided to the patient about relevant issues, select "Yes".<br><br>The advice on risk factor or lifestyle modification should include smoking cessation, improved diet, regular exercise, and levels of appropriate alcohol consumption, however, each risk factor does not need to be listed separately to answer "Yes". |

13.001 If no, select reason:

| | |
|---|---|
| Definition: | Reason why patient was not provided with information about behaviour change for modifiable risk factors prior to discharge |
| Values: | SCI = Severe cognitive impairment<br>SMI = Severe communication impairment<br>TF = Treatment was futile (e.g. advance care directive is enacted/ the patient is on a palliative care pathway)<br>DAH = Discharged to another hospital<br>PR = Patient refused<br>OTH = Other |

13.011 For patients who are currently smoking or recently quit, did the patient receive smoking cessation advice?

(Yes / No / Not documented / Not applicable)

| | |
|---|---|
| Definition | Smoking cessation advice is defined as simple advice to quit (written or verbal) and the offer of referral to Quitline and/or prescription of smoking cessation medication, or family alone if patient has severe aphasia or cognitive impairments |
| Main Source of Standard | Representational Standard: Quit Victoria, 3 step quit smoking brief advice -AAH model, Melbourne. Referenced in RACGP Smoking Cessation Guidelines for Health Professionals (2020) |
| Recording Guidance | Patient medical records – nursing notes, medical notes, medication chart or discharge summary, dedicated smoking cessation clinical pathway form |

| | |
|---|---|
| Help Notes | Quit's brief advice model - *Ask, Advise, Help* consists of three steps:<br>• Ask all patients about smoking status and document this in their medical record<br>• Advise all patients who smoke to quit in a clear, non-confrontational, personalised way and advise of the best way to quit<br>• Help all patients who smoke to quit by referring to Quitline and by prescribing, or facilitating access to, smoking cessation pharmacotherapy.<br>There should be documentation on smoking status prior to the stroke. "Recently quit" is defined as within the last month prior to the stroke.<br><br>If the patient does not smoke, or quit greater than 1 month prior to stroke, select 'not applicable'.<br><br>Select 'Yes' if the person is a smoker and there is documentation tobacco dependence treatment was provided. Such treatment involves behavioural intervention or counselling to quit smoking (or referral to Quitline) or pharmacotherapy as clinically appropriate (e.g. nicotine replacement therapy or other stop smoking medications such as varenicline).<br><br>If there is documentation the patient is currently smoking or recently quit but no record of any advice provided (referral to Quitline/pharmacotherapy) then select 'No'.<br><br>If there is no documentation of smoking status AND no documented advice then select 'Not documented'.<br><br>If the patient has severe aphasia or cognitive impairments then select 'Yes' if there is documented evidence advice was provided to the family/carer. |

**Medication prescribed on discharge**

13.020 On discharge was the patient prescribed antithrombotics? (Yes / No / Unknown / Contraindicated)

| | |
|---|---|
| Definition: | Evidence that antithrombotic medication was prescribed at discharge.<br>Antithrombotics is a common term that includes antiplatelets and any other blood thinning agents such as anticoagulants<br>e.g. warfarin, enoxaparin sodium. |
| Auditing Guidance: | Select "Yes" if the patient was prescribed an antiplatelet or antithrombotic agent on discharge from their acute episode of care. This is irrespective of discharge destination. Select "Yes" if prescribed prior to discharge from inpatient care. |

| | |
|---|---|
| | Select "No" if the patient did not receive an antiplatelet or antithrombotic agent on discharge from their acute episode of care.<br><br>Select "Contraindicated" if the patient died during their inpatient acute episode or if they were placed on a palliative care pathway (e.g. death imminent) during their acute hospital admission.<br><br>If unable to locate a drug chart or details of medications prescribed on discharge, select "Unknown".<br><br>If it is unclear whether an antiplatelet or antithrombotic agent was prescribed on discharge, select "Unknown".<br><br>If the patient died during their inpatient acute episode of care, then select "No".<br><br>Antiplatelet /Antithrombotic agents commonly include (but are not limited to) Adenosine Diphosphate Receptor Inhibitors such as Clopidogrel, Prasugrel and Ticagrelor; Adenosine Reuptake Inhibitors like Dipyridamole with Aspirin or antithrombotic such as (but not limited to) Warfarin or Aspirin. |

13.030 – 13.100 If yes, please specify type of antithrombotic medication prescribed at discharge.

Type - Aspirin, Clopidogrel, Dipyridamole MR, Other antiplatelet drug, Warfarin, Dabigatran, Rivaroxaban, Apixaban, Other anticoagulant.

13.110 If no, select reason:

| Definition: | Reason why antithrombotic medication was not prescribed at discharge. |
|---|---|
| Values: | PR = Patient refused<br>UR = Under review<br>TF = Treatment was futile (e.g. advance care directive is enacted/ the patient is on a palliative care pathway)<br>NR = No reason given |

13.120 On discharge was the patient prescribed antihypertensives? (Yes / No / Unknown / Contraindicated)

| Definition: | Evidence that patient was discharged on antihypertensive medication. |
|---|---|
| Auditing Guidance: | Select "Yes" if the patient was prescribed an antihypertensive agent on discharge from their current episode of care. This is irrespective of discharge destination. Select "Yes" if prescribed prior to discharge from inpatient care.<br><br>Select "No" if the patient did not receive an antihypertensive agent on discharge from their acute episode of care. If unable to locate a drug chart or details of medications prescribed on discharge, select "Unknown". |

| | |
|---|---|
| | Select "Contraindicated" if the patient died during their inpatient acute episode of care or if they were placed on a palliative care pathway (e.g. death imminent) during their hospital admission and medications were to be ceased.<br><br>Contraindications include symptomatic hypotension and allergic reaction.<br><br>If it is unclear whether an antihypertensive agent was prescribed on discharge, select "Unknown".<br><br>If the patient died during their inpatient acute episode of care, then select "No".<br><br>Antihypertensive agents commonly include angiotensin converting enzyme inhibitors (e.g. Perindopril, Ramipril) with or without diuretic and angiotensin II receptor antagonists (e.g. Telmisartan, Losartin) with or without diuretic. Other agents include alpha blockers (e.g. Prazosin), beta blockers (e.g. Atenolol, Metoprolol), calcium channel blockers (e.g. Amlodipine, Diltiazem hydrochloride) and thiazide diuretics. |

13.200 If no, select reason:

| Definition: | Reason why antihypertensive agents were not prescribed at discharge |
|---|---|
| Values: | PR = Patient refused<br>UR = Under review<br>TF = Treatment was futile (e.g. advance care directive is enacted/ the patient is on a palliative care pathway)<br>NR = No reason given |

13.210 On discharge was the patient prescribed lipid-lowering treatment? (Yes / No)

| Definition: | Prescription of lipid lowering medication at discharge. |
|---|---|
| Auditing Guidance: | Select "Yes" if the patient was prescribed a lipid lowering agent on discharge from their current episode of care. This is irrespective of discharge destination. Select "Yes" if prescribed prior to discharge from inpatient care.<br><br>Select "No" if the patient did not receive a lipid lowering agent on discharge from their acute episode of care.<br><br>Select "Contraindicated" if the patient died during their inpatient acute episode of care or if they were placed on a palliative care pathway (e.g. death imminent) during their acute hospital admission and medications were to be ceased.<br><br>If unable to locate a drug chart or details of medications prescribed on discharge, select "Unknown".<br><br>If it is unclear whether a lipid lowering medication was prescribed on discharge, select "Unknown". |

| | |
|---|---|
| | Lipid lowering agents commonly include (but are not limited to) statins (e.g. Atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin, and pitavastatin) and fibrates (e.g. gemfibrozil and fenofibrate). Others include ezetimibe, colesevelam, torcetrapib, avasimibe, implitapide, and niacin. |

13.240 If no, select reason:

| Definition: | Reason why antihypertensive agents were not prescribed at discharge |
|---|---|
| Values: | PR = Patient refused<br>UR = Under review<br>TF = Treatment was futile (e.g. advance care directive is enacted/ the patient is on a palliative care pathway)<br>NR = No reason given |

## DISCHARGE INFORMATION

14.000 Patient deceased during acute care? (Yes / No)

14.010 If yes, Date of death DD/MM/YYYY

14.070 Is the date of discharge known? (Yes / No)

14.080 Date of discharge DD/MM/YYYY

| Definition: | The date the patient was discharged (and accuracy) from current episode of care. |
|---|---|
| Auditing Guidance: | The patient may have several inpatient separations for acute treatment during a single episode of rehab care. If appropriate time between admissions use the final date of discharge and combine the rehab episode of care into one for audit purposes. |

14.150 What is the discharge ICD 10 Classification Code?

| Definition: | The principal diagnosis is defined as the diagnosis established after investigation to be chiefly responsible for occasioning the patient's episode of care in hospital, as represented by the International Classification of Disease code (ICD-10-AM). The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM). |
|---|---|
| Values: | If you do not have access to this information, we suggest you categorise your patients as either haemorrhagic, ischaemic, or not specified as per one of the three ICD codes listed below:<br>Haemorrhagic strokes as 161.9 – Intracerebral haemorrhage, unspecified. |

| | |
|---|---|
| | Ischaemic strokes as 163.9 – Cerebral infarction, unspecified.<br>Unknown as 164 – Stroke, not specified as haemorrhage or infarction. |
| Auditing Guidance: | ICD-10-AM diagnosis codes are assigned to patient records after acute discharge by Health Information staff. |

14.160 What is the discharge destination/mode?

| Definition: | Separation of person and place to which person is released (discharge/transfer/death) as represented by a code. |
|---|---|
| Values: | Discharge/transfer to (an)other acute hospital.<br>Discharge/transfer to a residential aged care service, unless this is the usual place of residence.<br>Statistical discharge - type change.<br>Left against medical advice/discharge at own risk.<br>Died.<br>Other.<br>Usual residence (e.g. home) with supports.<br>Usual residence (e.g. home) without supports.<br>Inpatient rehabilitation.<br>Transitional care services. |
| Auditing Guidance: | Select “Discharge/transfer to (an)other acute hospital” for admission or transfer to another acute hospital, including transfer to a psychiatric unit or to a palliative care hospital.<br><br>Select “Discharge/transfer to a residential aged care service” for residential aged care services, special accommodation, and aged care hostels, unless this is the usual place of residence. However, if the patient previously resided in residential aged care but the level of residential aged care service has increased, this code is selected.<br><br>Select “Statistical discharge - type change” for date of discharge from an acute episode to a sub-acute treatment phase but still an inpatient (may also be recorded as SNAP).<br><br>Select “Left against medical advice/discharge at own risk” for self-discharge.<br><br>The code “Died” refers to in hospital death, this variable will auto complete to “Died” and grey out. If “Yes” has been selected for “Patient deceased during hospital care” on User Interface.<br><br>Select “Inpatient rehabilitation” for any rehabilitation ward or part of a ward where the patient is undergoing rehabilitation as an inpatient, prior to discharge. Beds in a rehabilitation ward may be allocated to the specialty of |

| | |
|---|---|
| | rehabilitation medicine or to any other specialty. Note: geriatric assessment units, such as Geriatric Evaluation and Management (GEM) Units are excluded. GEM Units should be coded as transfers to a Transitional Care Service.<br><br>Select "Usual residence (e.g. home) with support" for private residences (such as houses, flats, units, units in a retirement village, caravans, mobile homes, boats, marinas) in which patients are provided with support in some way by staff or volunteers (including family members or spouse). This includes discharge back to residential aged care service when it is a patient's usual residence. Support may be provided by a family member or friend who may or may not be living in the same residence and is identified as providing regular care and assistance. Support may also be provided on a paid basis and may include community care, meals on wheels or other support organisations.<br><br>Select "Other" for discharge to welfare institution (includes prisons, hostels and group homes providing primarily welfare services) or other than those listed.<br><br>Select "Usual residence (e.g. home) without supports" for private residences (such as houses, flats, units, units in a retirement village, caravans, mobile homes, boats, marinas) in which patients will not be provided with any support.<br><br>Select "Transitional care service" for Transition care either at home or in a live-in setting. When it is offered in a live-in setting, it includes hospital-in-the-home, and home-based rehabilitation services. Hospital staff may create an internal transfer/separation to the Geriatric Evaluation and Management (GEM) Unit, which should also be recorded as discharge to a Transition care service. Even in self-discharge the destination should be recorded. |

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))

| | |
|---|---|
| Definition: | Documented evidence that the patient, or the patients' family, have received a plan that outlines care in the community post discharge that has been developed with input from both the multi-disciplinary team and the patient, or in situations where the patient is no longer able to make decisions, with the family or significant other.<br>The care plan should include the following information:<br>▪ risk factor modification<br>▪ any community services<br>▪ local stroke support services<br>▪ further rehabilitation or outpatient appointments |

| | |
|---|---|
| | ▪ appropriate contact numbers<br>▪ equipment needed. |
| Auditing Guidance: | A verbal discharge formulated with a patient is not considered a care plan.<br><br>A care plan is NOT a discharge summary developed and sent to subsequent health professionals (e.g. GP or community providers). It is a recovery plan kept by the patient and/or family. |

L14.20 If yes, did this include:

14.200 Patient

14.201 Family/carer

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))

| | |
|---|---|
| Definition: | Evidence that the patient's general practitioner and/or community providers were provided with a copy of the discharge summary |
| Auditing Guidance: | A record that the discharge summary has been sent is sufficient for a "Yes" response.<br>"Not applicable" can be answered if the patient is continuing care as an inpatient. |

14.211 If no select reason

| | |
|---|---|
| Definition: | Reason why the patient's general practitioner and/or community providers were not provided with a copy of the discharge summary |
| Auditing Guidance: | NGP = No GP contact documented<br>FOT = From overseas/travelling<br>OTH = 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)

| | |
|---|---|
| Definition: | Evidence that the patient was provided with a named contact in the hospital for post-discharge questions |

| | |
|---|---|
| Auditing Guidance: | "No but provided to family" may be used if the patient had cognitive impairment or communication issues that prohibited this process to include the patient.<br><br>Examples of a contact are stroke liaison nurse, stroke support group representative. Post discharge questions might concern outpatient's appointments, stroke support groups, maintenance exercise groups, outpatient rehabilitation appointments, neurology appointments, or secondary prevention appointments. |

**Dependency on discharge**

14.250 Functional status on discharge? (mRS) Score of 0 through to 6

| | |
|---|---|
| Definition: | Patient's modified Rankin Scale (0- 6) score at discharge |
| Auditing Guidance: | If mRS is known, enter one number, 0-6, with 6 = Death.<br><br>Please see full breakdown in previous question 6.470.<br><br>The modified Rankin Scale (mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke, and it has become the most widely used clinical outcome measure for stroke clinical trials. Independence= 0-2, dependence >=3, death = 6. |