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: **https://australianstrokecoalition.org.au/projects/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.

Contents

PATIENT DEMOGRAPHICS

2.09 Date of birth

Definition:	The date of birth of the person.
Values:	DD/MM/YYYY
Auditing Guidance:	If the day of birth is unknown, use 01 for the day (01/MM/YYYY).

	If the day and month of birth are unknown, enter 01/01/YYYY. If the date of birth is unknown, estimate the person's age in years to establish an approximate year of birth and enter 01/01/YYYY.

2.10 Age

Definition:	The age in (completed) years at the day of admission.
Values:	Calculated in years.
Auditing Guidance:	Auto-calculated from date of birth and date of admission.

2.13 Gender

Definition:	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code.
Values:	1 = Male 2 = Female 3 = Intersex or indeterminate 9 = Not stated/inadequately described
Auditing Guidance:	Record the gender as documented in the medical record. **If the gender in the medical record is different to self-identified gender:** document the patient self-identified gender. **If 'non-binary'**: select Intersex or indeterminate

2.17 Interpreter needed

Definition:	Whether an interpreter service is required by or for the person, as represented by a code.
Values:	1 = Yes 2 = No
Auditing Guidance:	Select Yes if the person requires an interpreter service for languages other than English or sign language.

2.18 Is the patient of Aboriginal/Torres Strait Islander origin?

Definition:	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. METeOR Identifier There are three components to the Commonwealth definition of identification: – descent; – self-identification; and – community acceptance. This variable is defined in terms of self-identification as being of Aboriginal or Torres Strait Islander origin'.
Values:	1 = Aboriginal but not Torres Strait Islander origin 2 = Torres Strait Islander but not Aboriginal origin 3 = Both Aboriginal and Torres Strait Islander origin 4 = Neither Aboriginal nor Torres Strait Islander origin 8 = Indigenous not otherwise described. 9 = Not stated/missing
Auditing Guidance:	Select the person's self-identified Aboriginal and Torres Strait Islander status in preference to other sources if they conflict.

ADMISSION AND TRANSFER INFORMATION

4.000 Onset date

4.010 Date unknown

Definition:	Date and accuracy of the symptom onset for the current stroke or TIA. This is known as the date the person was last seen, or known to be, 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:	4.000 DD/MM/YYYY 4.010 TRUE FALSE
Auditing Guidance:	Record the date stated by admitting or stroke physician in preference to other sources. When onset date is known, record the date and select **Accurate** for Date accuracy.

	If the day is unknown, format as 01/MM/YYYY and select **Estimate** for Date accuracy. If the day and month is unknown, format as 01/01/YYYY and select **Estimate** for Date accuracy. If the person woke with symptoms of stroke/TIA (wake-up stroke), record the date that the person was last seen, or known to be well, i.e. unaffected by clinical features related to stroke or TIA. Leave blank and select **Unknown** (4.010) if no estimated onset date can be found.

4.030 Onset Time

4.04 Time accuracy

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:	4.030 hh:mm 4.040 KWN = Known time of onset UNC = If uncertain time of onset, then time last seen well WAK = If wake up stroke, then time last seen well TU = Time unknown
Auditing Guidance:	If person woke with symptoms of stroke/TIA , record the time the person was last known to be well, and select 'If wake up stroke, time last seen well'. If stroke onset time is unclear, then record the time last seen well, and select 'If uncertain time of stroke, then time last seen well'. If time given is indicative (e.g. Early afternoon), record the specified time from the list in the Data Dictionary under Further Information, and select 'If uncertain time of stroke, then time last seen well'.

	Select Time Unknown for 4.040 Time accuracy, if stroke onset time is unknown or no estimated stroke onset time can be found. Record the time stated by admitting or stroke physician in preference to other sources if there is a conflict.

4.140 Did the stroke occur while the patient was in hospital?

Definition:	Stroke or Transient Ischaemic Attack (TIA) with onset during an episode of admitted patient care at your hospital for another condition.
Values:	1 = Yes 2 = No 9 = Unknown
Auditing Guidance:	Individual patient medical record – Admission form, discharge summary, history and medical /nursing notes. When you select a “Yes” or “Unknown” for this field, all variables 4.150, 4.160, 4.170, 4.180, 4.181, 4.190 and 4.200 are greyed out and disabled. Note that this refers to onset of symptoms at your hospital only; if stroke/TIA onset occurred at another hospital, record as ‘No’.

4.150 Date of arrival to emergency department

Definition:	The date of patient presentation at the Emergency Department is the first recorded contact with an emergency department staff member
Values:	4.150 DD/MM/YYYY
Auditing Guidance:	If the day is unknown, format as 01/MM/YYYY and select Estimate for Date accuracy. If a patient bypasses ED (either transferred from another hospital or admitted directly), record the date the patient entered the hospital as the ED arrival date, and select Estimate.

4.170 Time of arrival to emergency department

4.181 Unknown

Definition:	The time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process, whichever happens first.
Values:	4.170 hh:mm 4.181 TRUE FALSE
Auditing Guidance:	If time is unclear, enter an approximate time, and select Estimate. If a patient bypasses ED (either transferred from another hospital or admitted directly), record the time the patient entered the hospital or ambulance 'At destination' time as the ED arrival time, and select Estimate.

4.200 Did the patient arrive by ambulance?

Definition:	Person arrived at hospital via ambulance.
Values:	1 = Yes 2 = No 9 = Unknown
Auditing Guidance:	Select Yes if person arrived by road ambulance, Mobile Stroke Unit, air ambulance or helicopter rescue service. Select Unknown if mode of arrival is not documented or unclear.

4.290 Date of admission to hospital

Definition:	Date on which an admitted patient commences an episode of care.
Values:	4.290 DD/MM/YYYY
Auditing Guidance:	When the admission date is known record the date of admission and identify as "Accurate".

	If the day of admission is unknown, use 01 for the day (01/MM/YYYY) and identify as “Estimate”. If the day and month of admission is unknown, use 01 for the day and month (01/01/YYYY) and identify as “Estimate”. If patient not admitted (i.e. transferred to another hospital from Emergency Department, discharged directly to community from Emergency Department), select “Not admitted”

4.320 Time of admission to hospital

4.331 Unknown

Definition:	Time at which an admitted patient commences an episode of care.
Values:	4.320 hh:mm 4.331 TRUE FALSE
Auditing Guidance:	Enter the time admitted to acute care or inpatient unit; not the time of arrival to ED. If time is unclear, enter an approximate time, and select Estimate for Time accuracy.

4.360 What was the ward for initial admission?

4.370 Other (Specify)

Definition:	First ward to which the patient was admitted.
Values:	4.360 ▪ SU = Stroke unit ▪ NEU = Other neuroscience ward ▪ MW = Medical ward ▪ SW = Surgical ward ▪ MSW = Mixed med/surgical ward

	▪ RW = Rehabilitation ward ▪ ICU = ICU ▪ UNK = Unknown ▪ OTH = Other 4.370 Free text
Auditing guidance:	Select the first ward to which the patient was admitted. If the ward is not listed, select "Other" and provide details.

4.380 Was the patient treated in a stroke unit at any time during their stay?

Definition:	Patient admitted to a Stroke Unit at some stage during their acute episode of care. The minimum criteria for a stroke unit is defined as: • Co-located beds within a geographically defined unit. • 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). • Interdisciplinary team meets at least once per week to discuss patient care. • 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).
Auditing Guidance:	Select Yes if the person was admitted at any time during their episode of care to an acute care stroke unit, as defined by the National Acute Stroke Services Framework 2019; see Data Dictionary for further details. AuSCR records: definition excludes rehabilitation only stroke units.

	Stroke Foundation Rehabilitation Audit: includes rehabilitation only stroke units as per National Rehabilitation Stroke Services Framework 2022. Queensland Health: includes hospital wards/units with beds listed as having dedicated STKU codes on HBCIS.

4.390 Date of admission to stroke unit

Definition:	The date the patient was admitted to the stroke unit as an inpatient.
Values:	DD/MM/YYYY
Auditing Guidance:	Question enabled if "Yes" answered to "was the patient treated in a stroke unit at any time during their stay?" (Ref 4.380) If there is an administrative data set that included this metric then it can be extracted from that dataset. If there is no administrative dataset then the date of admission to the stroke unit (acute or combined/comprehensive unit) needs to be extracted from the progress notes. Specifically check the nursing notes as to the time and date for admission

4.400 Time of admission to stroke unit

4.410 Not documented

Definition:	The time the patient was admitted to the stroke unit as an inpatient.
Values:	4.400 hh:mm, 4.410 TRUE FALSE
Auditing Guidance:	Question enabled if "Yes" answered to "Was the patient treated in a stroke unit at any time during their stay?" (Ref 4.380) If time of admission is unknown (i.e. cannot be determined) or not documented, select "Not documented" box

4.420 Date of discharge from stroke unit

Definition:	The date the patient was discharged from the stroke unit as an inpatient
Values:	DD/MM/YYYY
Auditing Guidance:	Question enabled if "Yes" answered to "Was the patient treated in a stroke unit at any time during their stay?" (Ref 4.380) If there is an administrative data set that included this metric then it can be extracted from that dataset. If there is no administrative dataset then the date of discharge to the stroke unit (acute or combined/comprehensive unit) needs to be extracted from the progress notes. Specifically check the nursing notes as to the date of discharge.

PRE STROKE HISTORY

History of known risk factors

L 6.01 Did the patient have any history of known risk factors prior to admission?

6.010 Atrial Fibrillation

Definition:	Atrial fibrillation is the most common form of cardiac arrhythmia and manifests as heartbeats that occur at irregular intervals.
Values:	1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	Answer "Yes" if the patient is in persistent, permanent or paroxysmal atrial fibrillation PRIOR to this admission.

6.020 Previous Stroke

Definition:	Previous history of stroke.
Values:	.020 1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	Select "Yes" if there is a history of stroke, probable stroke, or history consistent with stroke PRIOR to this admission. This may be described verbally by the patient, or documented in previous medical notes or confirmed on brain imaging.

Dependency prior to admission

6.470 Functional status prior to stroke? (mRS)

6.48 Unknown/derive

6.490 Can the patient walk on their own (i.e. without the assistance of another person, but may include walking aid)?

6.500 If the patient can't walk on their own, can they walk if someone is helping them?

6.510 If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)?

6.520 If the patient can perform simple personal activities do they need help with more complex usual activities (driving, golf, finances, household bills, work tasks)?

6.530 If the patient has no disability, do they have any symptoms?

Definition:	Patient's premorbid modified Rankin score.
Values:	6.470 Numerical 0-5 6.48 TRUE FALSE 6.490 – 6.530 1= Yes 2= No
Auditing Guidance:	If mRS is known, enter one number, 0-5 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent, and requiring constant nursing care and attention If unknown, select "Unknown/derive" and calculate using following algorithm: a) Can the patient walk on their own? • If No go to question b • If Yes go to question c

	b) If the patient can't walk on their own can they walk if someone is helping them? • If Yes score 4 • If No score 5 c) If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)? • If Yes score 3 • If No go to question d d) If he can perform simple personal activities does he need help with more complex usual activities (driving, golf, finances, household bills, work tasks)? • If Yes score 2, • If No go to question e e) If he has no disability does he have any symptoms? • If Yes score 1 • If No score 0 If two options appear equally valid and if further questions are considered unlikely to clarify choice, then the more severe category should be selected. 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. The variable is used as a measure of stroke severity at time of hospital admission (e.g. first few hours of presentation).

	The variable can be used, in statistical models, to make corrections for differences in patient case mix to ensure comparisons of quality of care and/or health outcomes between patient sub-groups are valid. This variable is not used as a functional outcome measure. Further information and training can be found at http://rankin-english.trainingcampus.net/uas/modules/trees/windex.aspx Ref: Lees, K. Modified Rankin Scale: A training and certification resource. University of Glasgow.

ACUTE CLINICAL DATA

7.020 Did the patient have a validated stroke screen in ED

Definition:	Use of a validated stroke screening tool to assist in rapid accurate assessment for all people with stroke.
Values:	▪ Yes ▪ No ▪ Unknown
Auditing Guidance:	There are a number of validated stroke screening tools currently in use in Australia and internationally, including the Face Arm Speech Test (FAST), and Recognition of Stroke in the Emergency Room (ROSIER).

)

Brain Imaging

7.410 Did the patient have a brain scan after this stroke?

Definition:	Performance of brain imaging (Computerised Tomography – CT- or Magnetic Resonance Imaging - MRI) after this episode of stroke. This includes brain imaging conducted at your hospital or at another facility prior to arrival at your hospital.
Values:	1 = Yes 2 = No

Auditing guidance:	Select “Yes” if there is documented evidence that the patient had a brain scan (CT/MRI) for this current episode for stroke. Select “No” if there is no documented evidence that the patient had a brain scan (CT/MRI) for this current episode of stroke.

7.420 Was brain scan done within your hospital?

Definition:	Performance of brain imaging (CT scan or MRI) within your hospital.
Values:	1 = Yes 2 = No (done elsewhere)
Auditing guidance:	If the patient had received their brain scan at another hospital prior to admission to your hospital please indicate “No”. This question refers to computed tomography (CT) or magnetic resonance imaging (MRI).

7.430 Date of first brain scan after the stroke?

Definition:	The date of the initial brain scan (Computerised Tomography - CT or Magnetic Resonance Imaging – MRI) was conducted after this episode of stroke. The initial brain scan includes brain imagining conducted at your hospital or at another facility prior to arrival at your hospital.
Values:	DD/MM/YYYY
Auditing Guidance:	Record date of first brain scan following this stroke, whether conducted at your hospital or elsewhere.

7.440 Time of first brain scan after the stroke?

7.450 Not documented

Definition:	The time that the initial brain scan (Computerised Tomography - CT or Magnetic Resonance Imaging – MRI) was conducted after this episode of stroke. The initial brain scan includes brain imagining conducted at your hospital or at another facility prior to arrival at your hospital.
Values:	7.440 hh:mm 7.450 TRUE FALSE
Auditing Guidance:	Where possible, record exact time of brain scan from radiology records.

	If brain imaging was performed prior to admittance to this hospital (e.g. inter-hospital transfer), record this time. Where patients arriving by ambulance are transferred directly to imaging before Emergency Department (ED) triage, record time of brain scan as usual, and record time of arrival to ED (4.170) as the ambulance "at destination" time, to avoid negative door-to-scan times.

7.550 Type of stroke

Definition:	The clinical diagnosis of stroke type.
Values:	TIA = Transient ischaemic attack Ischaemic = Ischaemic Haemorrhagic = Haemorrhagic Undetermined = Undetermined
Auditing Guidance:	This is not the ICD-10-AM code, but rather the clinical diagnosis. "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). "Ischaemic" stroke type should be selected if the brain imaging is consistent with cortical, sub-cortical, brainstem or cerebellar infarction. "Haemorrhage" stroke type should be selected if the brain imagining is consistent with intraventricular, intracerebral haemorrhage (ICH) or other non-traumatic intracerebral haemorrhage. "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 vascular imaging while in hospital?

Definition:	Performance of any diagnostic investigation that can identify carotid artery stenosis while patient was in hospital
Values:	1 = Yes 2 = No
Auditing Guidance:	Carotid stenosis is usually diagnosed by colour flow duplex ultrasound scan of the carotid arteries in the neck. Typically duplex ultrasound scan is the only investigation required for decision making (including proceeding to intervention) in carotid stenosis. 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. 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?

Definition:	Screening to determine if patient eligible for intravenous thrombolysis.
Values:	1 = Yes 2 = No 9 = Unknown
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. 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

Definition:	Administration of intravenous thrombolysis for those patients admitted with an ischaemic stroke. The administration of thrombolysis includes the provision of thrombolysis at your hospital or at another hospital prior to arrival at your hospital.
Values:	1 = Yes 2 = No 9 = 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. Select “No” if there is no documentation that patient, admitted with an ischaemic stroke, received thrombolytic therapy. Select “Unknown” if it cannot be determined whether thrombolytic therapy was provided e.g., unable to location relevant medication chart. Record thrombolytic therapy whether administered before admission to your hospital (e.g. transfer from another hospital) or within your hospital (either emergency department or inpatient unit/ward). 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 Date of delivery?

Definition:	The date thrombolysis therapy was first administered to the patient with an ischeamic stroke. The administration of thrombolysis includes the provision of thrombolysis at your hospital or at another hospital prior to arrival at your hospital.
Values:	DD/MM/YYYY
Auditing Guidance:	The date that thrombolysis was administered to the patient should reflect the date recorded on the patient's medication chart. If the date that thrombolysis was administered is known, then record the date. If the date that thrombolysis was administered to the patient is not known, then leave this variable blank. If the patient was thrombolysed prior to arriving at YOUR hospital for ongoing acute stroke management (i.e. inter-hospital transfer), the date the initial bolus was administered (i.e. date administered at referring site) should be recorded. This is regardless of whether they received intravenous or intra-arterial thrombolysis.

8.150 Time of delivery?

Definition:	The time thrombolysis therapy was first administered to the patient with an ischaemic stroke. .
Values:	hh:mm
Auditing Guidance:	The time that thrombolysis was administered to the patient should accurate reflect the time recorded on the patient's medication chart. If this is not clear or you are unable to locate the patient's medication chart then leave this variable blank. If the patient was thrombolysed prior to arriving at YOUR hospital for ongoing acute stroke management (i.e. inter-hospital transfer), the time the initial bolus was administered (i.e. time administered at referring site) should be recorded. This is regardless of whether they received intravenous or intra-arterial thrombolysis. Time is recorded to the nearest minute; however time to within 15 minutes of exact time is acceptable.

OTHER CLINICAL INFORMATION

Swallowing

9.070 Was a formal swallowing screen performed (i.e. not a test of gag reflex)?

Definition:	Swallow screen conducted by an appropriately trained health care professional such as a nurse or doctor utilising a formal swallow screen tool.
Values:	1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	Select "Yes" if there is documented evidence of a patient receiving a swallow screen by an appropriately trained healthcare professional. 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. 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. Select "Yes" if the patient had both a formal swallow screen regardless of whether a Speech Pathology assessment.

9.080 Date of screening

Definition	Date and accuracy of date that the swallow screen was conducted.
Values:	DD/MM/YYYY.
Auditing Guidance:	When the formal swallow screen date is known record the date of swallow screen and identify as accurate. If the day of formal swallow screen is unknown, use 01 for the day (01/MM/YYYY) and identify as estimate. If the day and month of the formal swallow screen is unknown, use 01 for the day and month (01/01/YYYY) and identify as estimate.

	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. Record the date and accuracy that the swallow screen was conducted regardless of whether the patient had a Speech Pathology assessment

9.10 Time of screening

9.101 Unknown

Definition:	Time that the swallow screen was conducted and accuracy.
Values:	9.100 hh:mm 9.101 TRUE FALSE
Auditing Guidance	Time is recorded to the nearest minute; however time to within 15 minutes of exact time is acceptable to be coded as "Accurate". If time of formal swallow screen is unclear, select an approximate time from the list below and identify as "Estimate".

Description of Time	Record Time as:
Middle of the night	03:00
Breakfast	08:00
Early morning	08:00
Morning	09:00
Late morning	10:00
Lunch	12:00
Midday or 12 Noon	12:00
Early afternoon	14:00
Afternoon or mid-afternoon	15:00
Late afternoon	16:00
Dinner/Supper	18:00
Early evening	19:00
Evening	21:00

	<table><tr><td>Late evening</td><td>22:00</td></tr><tr><td>Midnight</td><td>11.59</td></tr></table> If time of formal swallow screen is unknown, select “Unknown”. 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. Record the time and accuracy status that the swallow screen was conducted regardless of whether the patient had a Speech Pathology assessment. For in-hospital strokes or TIAs, i.e. stroke or TIA during an acute episode of admitted care for a different condition, then record the time and accuracy of when the patient received a formal swallow screen (tool) by an appropriately trained healthcare professional following onset of stroke or TIA symptoms.

9.120 Did the patient pass the screening?

Definition:	Outcome from formal swallow screen.
Values:	1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	**This does not include gag reflex testing or assessment.** Select “Yes” if they passed the formal swallow screen tool that was administered. Determination of outcome of swallow screen will depend on which formal swallow screen tool is utilised. The outcome of a gag reflex test or assessment does not constitute whether a patient has passed a swallow test as this is proven to be of little prognostic value for the ability to evaluate effectiveness of swallow.

9.130 Was a swallowing assessment by a speech pathologist recorded?

Definition:	Formal swallow assessment conducted by a speech pathologist during the acute phase of the patient’s hospital admission.
Values:	1 = Yes 2 = No 9 = Not documented

Auditing Guidance:	For in-hospital strokes or TIAs i.e. stroke or TIA during an acute episode of admitted care for a different condition, then record whether the patient received a formal swallow assessment by a speech pathologist within the first 24 hours of the onset of stroke or TIA symptoms.

9.140 Date of swallowing assessment?

Definition:	The date and date accuracy that the speech pathologist conducted a formal swallow assessment.
Values:	9.140 DD/MM/YYYY
Auditing Guidance:	When the swallow assessment date is known record the date of swallow assessment and identify as “Accurate”. If the day of swallow assessment is unknown, use 01 for the day (01/MM/YYYY) and identify as “Estimate”. If the day and month of the swallow assessment is unknown, use 01 for the day and month (01/01/YYYY) and identify as “Estimate”. For in-hospital strokes or TIAs, i.e stroke or TIA during an acute episode of admitted care for a different condition, then record the date and accuracy of the swallow assessment within the first 24 hours of the onset of stroke or TIA symptoms.

9.160 Time of swallowing assessment?

9.161 Unknown

Definition:	The time that the speech pathologist conducted a formal swallow assessment.
Values:	9.160 hh:mm 9.161 TRUE FALSE
Auditing Guidance:	Time is recorded to the nearest minute; however time to within 15 minutes of exact time is acceptable to be coded as “Accurate”. If time of formal swallow assessment by speech pathologist is unclear, select an approximate time from the list below and identify as “Estimate”.

Description of Time	Record Time as:
Middle of the night	03:00
Breakfast	08:00
Early morning	08:00

	Morning	09:00
	Late morning	10:00
	Lunch	12:00
	Midday or 12 Noon	12:00
	Early afternoon	14:00
	Afternoon or mid-afternoon	15:00
	Late afternoon	16:00
	Dinner/Supper	18:00
	Early evening	19:00
	Evening	21:00
	Late evening	22:00
	Midnight	11.59

If time of formal swallow assessment by a speech pathologist is unknown, select “Unknown”.

For in-hospital strokes or TIAs, i.e stroke or TIA during an acute episode of admitted care for a different condition, then record the time and accuracy of the swallow assessment within the first 24 hours of the onset of stroke or TIA symptoms.

L9.18 Was the swallow screen or swallowing assessment performed before the patient was given:

9.180 Oral medications

9.190 Oral food or fluids

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. 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. Select “Not documented” if there is no documented.

Mobilisation

9.360 Was the patient able to walk independently on admission? (

Definition:	Ability to walk unaided or without any form of assistance, at the time of arrival. 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. However, for patients that experience a stroke or TIA during an episode of admitted patient care for a different condition (i.e inhospital stroke or TIA) then this is assessed within the first 24 hours of onset of their stroke symptoms.
Values:	1 = Yes 2 = No 9 = Not documented
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. For inhospital strokes or TIA's i.e. stroke or TIA during an acute episode of admitted care for a different condition, then record their ability to walk within the first 24 hours of the onset of stroke or TIA symptoms. For inter-hospital transfers who were admitted with a stroke or TIA, record the patient's ability to walk within the first 24 hours of arrival to YOUR hospital. In circumstances where the patient is admitted with a stroke or TIA and has a subsequent stroke during the same acute episode of care, record their ability to walk independently at the time of arrival to hospital for the initial stroke in relation to the same episode of care. Examples of independent mobility: ▪ Patient walked independently (no equipment, no help from another person) ▪ Patient walked with assistance from an assistive device (e.g., walking stick or frame) ▪ Patient walked to and from bathroom ▪ Patient received supervision Examples of not being able to mobilise independently:

	▪ Patient needed assistance from another person/s to walk ▪ Patient used a wheelchair or bed trolley ▪ Patient is only getting out of bed to the bedside commode (or up in chair) Select "No" if patient has a modified Rankin Score of 4 or 5. Select "No" if patient has a FIM™ Score of 4 or less. For children, select "No" in the following scenarios: • For child aged birth-30days: difficulty feeding. • For child aged < 2 years: change/reduction in motor activity including tone/power/movement reported by carers/noted in medical record. For child aged ≥ 2 years: inability to walk and/or use hand to grasp on admission

Continence

9.550 Was the patient assessed for urinary incontinence within 72hrs?

Definition:	Documented evidence that the patient was assessed for urinary incontinence within 72 hours of arrival at Emergency Department i.e. dysfunction of the bladder in which the patient has had an involuntary loss of urine.
Values:	1 = Yes 2 = No 9 = Not documented
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. 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).

	Check observation chart and patient notes.

9.610 Was the patient incontinent of urine (or required a urinary catheter) within the first 72 hours of stroke onset?

Definition:	Evidence that the patient was incontinent of urine within the first 72 hours of stroke onset.
Values:	1 = Yes 2 = No 9 = 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). Answer "Yes" if urinary catheter inserted within 72 hours of stroke onset.

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

Definition:	A management plan documented for urinary incontinence.
Values:	1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	The minimum content criteria are: (i) documentation of a specific care plan addressing urinary incontinence; (ii) a provisional diagnosis of the cause of the urinary incontinence; and (iii) other evidence of interventions to avoid complications and promote continence. 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). The plan should be consistent with current evidence-based guidelines or protocols.

Aphasia

9.870 Did the patient have aphasia?

Definition:	Evidence that patient had aphasia, a common communication deficit following stroke.
Values:	1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	Aphasia is an impairment of language, affecting the production or comprehension of speech, and the ability to read or write. 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 ▪ 2 = No ▪ 0 = No, but anticoagulent agent provided ▪ U = Unknown ▪ CI = Contraindicated
Auditing Guidance:	**This field is relevant to ischaemic stroke and TIA only. Where stroke type is intracerebral haemorrhage (ICH), select Contraindicated.**

	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. Select **No** if the person was administered an antiplatelet or anticoagulant **prior to presentation** at your hospital. 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. Select **Contraindicated** if stroke type is ICH, or if antiplatelet therapy is contraindicated for another reason. **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 Date 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.
Values:	10.030 DD/MM/YYYY
Auditing Guidance:	The date that hyperacute antiplatelets was given to the patient should reflect the date recorded on the patient's medication chart.

10.050 Time medication given
10.051 Unknown

Definition	The time (and accuracy) that antiplatelets were 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.
Values:	10.050 hh:mm 10.051 TRUE FALSE

Auditing Guidance:	The time that hyperacute antiplatelets was given to the patient should reflect the time recorded on the patient's medication chart. If the time that hyperacute antiplatelets was given to the patient is known, then record the time and identify as "Accurate". If time that hyperacute antiplatelets was provided to the patient is not known, then record "Unknown". This will disable the time and time accuracy fields.

Assessment and management of fever

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

Definition	Raised temperature (≥ 37.5^{0}C) recorded within 72 hours of admission.
Values	1 = Yes 2 = No 9 = Not documented

10.150 Was Was paracetamol for the first elevated temperature administered within 1 hour?

Definition:	Evidence paracetamol was given within 1 hour of elevated temperature.
Values:	1 = Yes 2 = No 3 = Already received regular paracetamol 4 = Contraindicated 9 = Not documented
Auditing Guidance:	Question enabled if answered "Yes" to "In the first 72 hours following admission did the patient develop a fever ≥ 37.5°C" (Ref 10.100)

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?

Definition:	Glucose level equal or exceeding 10mmols/l within 48 hours of admission
Values:	1 = Yes

	2 = No 9 = 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)

Definition:	Evidence that insulin was given within 1 hour of elevated finger prick glucose (if patient developed finger-prick glucose level of greater or equal to 10mmols/L)
Values:	1 = Yes 2 = No 9 = Not documented
Auditing Guidance:	Question enabled if "Yes" answered to "In the first 48 hours following ward admission did the patient develop a finger-prick glucose level of greater or equal to 10mmols/L?" (Ref 10.240) Ideally insulin administration should be via infusion but other methods are also acceptable to answer "Yes".

DVT prophylaxis

10.441 What type of DVT prophylaxis management did the patient receive?

Definition	Management strategy used for DVT prophylaxis
Values:	1= Low molecular weight heparin 2= Intermittent pneumatic compression 3= Both 4= None 5= Contraindicated (including independently mobile) 9= Unknown

Auditing Guidance:	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). Caution is required for those with low platelet count. Physical methods may be contraindicated for those with peripheral vascular disease (symptomatic, or those with absent lower limb pulses). Further anticoagulation is not indicated if the patient is already on an oral anticoagulant, except in very high-risk situations. Most hospitals have a DVT policy and so local policies should be consulted.

Communication and support for patient and family/carer

10.790 Did the patient and/or family receive information covering stroke, hospital management, secondary prevention and recovery (e.g. 'My Stroke Journey' booklet)?

Definition:	Evidence that information covering stroke, hospital management, secondary prevention and recovery was provided to patient and/or family.
Values:	1 = Yes 2 = No 9 = Not documented
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?

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.

Values:	1 = Yes 2 = No NR = Not required
Auditing Guidance:	Look for documented evidence that an individual would assume responsibility for care of the stroke survivor following discharge. A spouse or housemate is only classed as a "carer" if they provide care. 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

Definition:	Training provided to the patient's carer on specific needs the patients will have when returning home.
Values:	1 = Yes 2 = No
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
Values:	1 = Patient transferred to inpatient rehab or other acute care 2 = Carer declined 3 = Other

10.850 Did the carer receive a support needs assessment (e.g. physical, emotional, etc.)?

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.
Values:	1 = Yes 2 = No
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
Values:	1 = Patient transferred to inpatient rehab or other acute care 2 = Carer declined 3 = Other

ALLIED HEALTH MANAGEMENT

10.450 Was the patient seen by a physiotherapist?

Definition:	First assessment by a physiotherapist
Values:	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
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

10.470 Unknown

10.48 Time

10.49 Unknown

Definition:	Date/time of first physiotherapist assessment
Values:	10.460 DD/MM/YYYY 10.480 hh:mm 10.470, 10.490 TRUE FALSE
Auditing Guidance:	Answer “Unknown” if date of assessment not documented in patient notes.

10.500 Was the patient seen by an occupational therapist?

Definition:	First assessment by an occupational therapist
Values:	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
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.

10.510 Date

10.520 Unknown

10.53 Time

10.54 Unknown

Definition:	Date/time of occupational therapist assessment
Values:	10.510 DD/MM/YYYY 10.530 hh:mm 10.520, 10.540 TRUE FALSE
Auditing Guidance:	Answer “Unknown” if date of assessment not documented in patient notes.

10.550 Was the patient seen by a speech pathologist?

Definition:	First assessment by Speech Pathologist
Values:	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
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.

10.560 Date

10.570 Unknown

10.58 Time

10.59 Unknown

Definition:	Date/time of first speech and language therapist assessment.
Values:	10.560 DD/MM/YYYY 10.580 hh:mm 10.570, 10.590 TRUE FALSE
Auditing Guidance:	Answer "Unknown" if date of assessment not documented in patient notes.

10.600 Was the patient seen by a social worker?

Definition:	First assessment by social worker.
Values:	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
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.

10.610 Date

10.620 Unknown

10.63 Time

10.64 Unknown

Definition:	Date/time patient was first seen by social worker.
Values:	10.610 DD/MM/YYYY 10.630 hh:mm 10.620, 10.640 TRUE FALSE
Auditing Guidance:	Answer "Unknown" if date of assessment not documented in patient notes.

10.650 Was the patient seen by a dietitian?

Definition:	First assessment by a dietitian.
Values:	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
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

10.670 Unknown

10.68 Time

10.69 Unknown

Definition:	Date/time patientwas first seen by dietitian.
Values:	10.660 DD/MM/YYYY 10.680 hh:mm 10.670, 10.690 TRUE FALSE
Auditing Guidance:	Answer “Unknown” if date of assessment not documented in patient notes.

10.700 Was the patient seen by a psychologist?

Definition:	First assessment by a psychologist.
Values:	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
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”). “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.

10.71 Date

10.72 Unknown

10.730 TIme

10.740 Unknown

Definition:	Date/timewas first seen by a psychologist.
Values:	10.710 DD/MM/YYYY 10.730 hh:mm 10.720, 10.740 TRUE FALSE
Auditing Guidance:	Answer “Unknown” if date of assessment not documented in patient notes.

COMPLICATION DURING HOSPITAL ADMISSIONS

L11.16 Did the patient have any of the following complications during their admission?

11.290 New onset atrial fibrillation

Definition:	Complications documented while the patient was in hospital.
Values:	1 = Yes 2 = 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).

FURTHER REHABILITATION AND COMMUNITY RE-INTEGRATION

12.000 Was an assessment for rehabilitation performed?

Definition:	Performance of a formal assessment for rehabilitation to determine the patient's rehabilitation needs and the optimal way to meet these needs.
Values:	1 = Yes 2 = No 9 = Unknown
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).

12.030 Did the assessment identify the need for ongoing rehabilitation?

Definition:	Identification of patient need for ongoing rehabilitation as a result of the rehabilitation assessment.
Values:	1 = Yes 2 = No 9 = Unknown

12.040 Was a referral made to rehabilitation?

Definition:	Evidence that patient was referred to rehabilitation services.
Values:	1 = Yes 2 = No 9 = Unknown

12.051 If yes, Type

12.06 Other (Specify)

Definition:	Location where ongoing rehabilitation will be delivered.
Values:	12.051 IR = Inpatient rehabilitation OR = outpatient rehabilitation CRH = community rehabilitation home based

	CRD = community rehabilitation day hospital ESD = early supported discharge service GEM = GEM rehab TCR = Transition care residential TCC = Transition care community IH = Individual home based IC = Individual centre based 12.060 OTH = Other
Auditing Guidance:	Question enabled if “Yes” answered to “Was a referral made to rehabilitation?” (Ref 12.040) Select the location where rehab will be delivered. If not listed, select “Other” and provide details. **Inpatient rehabilitation** - includes care within a hospital setting (either on a mixed rehabilitation unit, a comprehensive stroke unit, or a stroke rehabilitation unit). **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. **Community home based rehabilitation** - includes services that provide therapy within a home setting (sometimes referred to ‘Rehabilitation In The Home’ [RITH]). This service is accesses after inpatient rehabilitation (and so not to be confused with ESD). May be described as a transitional care service if active rehabilitation is provided. **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 outpatients setting. **Community rehabilitation day hospital** - involves the patient receiving rehabilitation via day hospital setting. **Early Supported Discharge (ESD)** - service is a service that aims to allow early discharge from hospital but provide similar intensity and care within patients home. This service replaces inpatient rehabilitation services. It is not simply transitional care services (unless there is full multidisciplinary team with higher intensity). **Other** - may include transitional care services (which focus on coordinating support in the community rather than active rehabilitation). May also include Geriatric Evaluation and Management (GEM) units where inpatient care is provided but is more around assessment than active rehabilitation.

SECONDARY PREVENTION

13.000 Is there evidence of patient education about behaviour change for modifiable risk factors prior to discharge?

Definition:	Evidence that patient was provided with information about behaviour change for modifiable risk factors (lifestyle and medication adherence) prior to discharge.
Values:	1= Yes 2= No
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". 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".

13.01 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 SMI = Severe communication impairment TF = Treatment was futile (e.g. advance care directive is enacted/ the patient is on a palliative care pathway) DAH = Discharged to another hospital PR = Patient refused OTH = Other

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

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
Values:	1 = Yes 2 = No 9 = Not documented NA = Not applicable
Help Notes	Quit's brief advice model - *Ask, Advise, Help* consists of three steps: • Ask all patients about smoking status and document this in their medical record • Advise all patients who smoke to quit in a clear, non-confrontational, personalised way and advise of the best way to quit • Help all patients who smoke to quit by referring to Quitline and by prescribing, or facilitating access to, smoking cessation pharmacotherapy. There should be documentation on smoking status prior to the stroke. "Recently quit" is defined as within the last month prior to the stroke. If the patient does not smoke, or quit greater than 1 month prior to stroke, select 'not applicable'. 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). 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'. If there is no documentation of smoking status AND no documented advice then select 'Not documented'. 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?

Definition:	Evidence that antithrombotic medication was prescribed at discharge.
Values:	1 = Yes 2 = No 3 = Contraindicated 9 = Unknown
Auditing Guidance:	Select “Yes” if the patient was prescribed 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 antithrombotic agent on discharge from their acute episode of care. Select ‘Contraindicated’ if: 1) the patient died or were placed on a palliative care pathway during their acute hospital admission; 2) there is documentation of a clinical reason for not prescribing antithrombotic medication because of the potential for harm, e.g. the patient has suffered a recent intracerebral haemorrhage. . If unable to locate a drug chart or details of medications prescribed on discharge, select “Unknown”. Select “unknown” f it is unclear whether an antithrombotic agent was prescribed on discharge.

L13.03 If yes, please specify

13.030 Aspirin
13.040 Clopidogrel
13.050 Dipyridamole MR
13.055 Other antiplatelet drug
13.060 Warfarin
13.070 Dabigatran
13.080 Rivaroxaban
13.090 Apixaban
13.100 Other anticoagulant

Definition:	Type of antithrombotic medication prescribed at discharge.
Values:	1 = Yes 2 = No

13.110 If no, select reason:

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

13.120 On discharge was the patient prescribed antihypertensives?

Definition:	Evidence that patient was discharged on antihypertensive medication.
Values:	1 = Yes

	2 = No 3 = Contraindicated 9 = Unknown
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. 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: 1) the patient died or was placed on a palliative care pathway during their acute hospital admission; 2) there is documentation of a clinical reason for not prescribing antihypertensive medication because of the potential for harm; 3) there is documentation that antihypertensive medication was not required as blood pressure was below the target range. If it is unclear whether an antihypertensive agent was prescribed on discharge, select “Unknown”.

13.200 If no, select reason:

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

13.210 On discharge was the patient prescribed lipid-lowering treatment?

Definition:	Prescription of lipid lowering medication at discharge.
Values:	1 = Yes 2 = No

	9 = Unknown 3 = Contraindicated
Auditing Guidance:	Select "Yes" if the patient was prescribed a lipid lowering medication on discharge from their current 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 a lipid lowering medication on discharge from their acute episode of care. Select 'Contraindicated' if 1) the patient died or was placed on a palliative care pathway during their acute hospital admission; 2) there is documentation of a clinical reason for not prescribing lipid lowering medication because of potential for harm of because it is clinically inappropriate, e.g. stroke mechanism is unrelated to atherosclerosis, low-density lipoprotein (LDL) already in treated target range, abnormal liver function (x3 above normal range). If unable to locate a drug chart or details of medications prescribed on discharge, select "Unknown". 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. Refer to MIMS for full list.

13.240 If no, select reason:

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

DISCHARGE INFORMATION

14.080 Date of discharge

Definition:	Date of discharge from current episode of care
Values:	DD/MM/YYYY
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.

14.160 What is the discharge destination/mode?

14.161 Please specify (if discharged/transferred to residential aged care service)

Definition:	Separation of person and place to which person is released (discharge/transfer/death) as represented by a code.
Values:	14.160 1 Discharge/transfer to (an)other acute hospital 2 Discharge/transfer to a residential aged care service, unless this is the usual place of residence 5 Statistical discharge - type change 6 Left against medical advice/discharge at own risk 8 Died 9 Other 10 Usual residence (e.g. home) with supports 11 Usual residence (e.g. home) without supports 12 Inpatient rehabilitation 13 Transitional care services 14.161 LLRC Low level residential care HLRC High level residential care
Auditing Guidance:	

	14.160: 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. 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. 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). Select **"Left against medical advice/discharge at own risk"** for self discharge. 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. 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. 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.

	Select **"Other"** for discharge to welfare institution (includes prisons, hostels and group homes providing primarily welfare services) or other than those listed. 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. Select **"Transitional care service"** for Transition care either at home or in a live-in setting. When it's 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. 14.161: Select **"Low level residential care"** for discharge to low level residential services (formerly nursing homes: low level care, special accommodation and aged care hostels) and multipurpose services or multipurpose centres, that are providing low level care. This category includes Indigenous Flexible Pilots. Select **"High level residential care"** for discharge to high level residential services (formerly nursing homes) and multipurpose services or multipurpose centres that are providing high level care. This category includes Indigenous Flexible Pilots and private nursing home for the purpose of palliative 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)?

L14.20 If Yes, did this include:

14.200 Patient

14.201 Family/carer

Definition:	▪

	Documented evidence that the patient, or the patient's family, have received an individualised plan that outlines care in the community post discharge (i.e. written specifically for the patient, NOT generic information and NOT a copy of the discharge summary provided to other health professionals. Care plans are 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. The care plan should include the following information: - Rehabilitation goals - Lifestyle modifications and medications required to manage risk factors - Any equipment needed - Follow up appointments - Contact details for ongoing support services in the community
Values:	14.190 1 = Yes 2 = No 9 = Not known NA = Not applicable (remains in a hospital setting e.g. inpatient rehabilitation or other acute care) 14.200 – 14.201 Yes

	No
Auditing Guidance:	Select Yes if there is documented evidence that the patient or their family have received an individualised care plan outlining post discharge care. The plan must meet the criteria outlined in the Acute Stroke Clinical Care Standard. Select Not Applicable if the patient remains in a hospital setting.

14.202 Did the patient refuse developing a care plan?

Definition:	Documented evidence that the patient was offered to the opportunity to develop a care plan but refused
Values:	1 = Yes 2 = No 9 = Unknown
Auditing Guidance:	Question enabled if “No” answered for “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)?” (Ref 14.190)

Dependency on discharge

14.250 Functional status on discharge

14.260 Unknown/derive

14.265 Is the patient alive?

14.270 Can the patient walk on their own (ie without the assistance of another person, but may include walking aid)?

14.280 If the patient can't walk on their own can they walk if someone is helping them?

14.290 If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)?

14.300 If the patient can perform simple personal activities do they need help with more complex usual activities (driving, golf, finances, household bills, work tasks)?

14.310 If the patient has no disability do they have any symptoms?

Definition:	Patient's modified Rankin Scale (0- 6) score at discharge
Values:	User Interface: 14.250 Drop down list 14.260 Tick box 14.265- 14.310 Radio buttons
Auditing Guidance:	If mRS is known, enter 0-5 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention If unknown, select "Unknown/derive" and calculate using following algorithm: a) Can the patient walk on their own? • If No go to question b • If Yes go to question c b) If the patient can't walk on their own can they walk if someone is helping them? • If Yes score 4 • If No score 5

	c) If the patient can walk on their own (includes walking aids) do they need help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)? • If Yes score 3 • If No go to question d d) If he can perform simple personal activities does he need help with more complex usual activities (driving, golf, finances, household bills, work tasks)? • If Yes score 2, • If No go to question e e) If he has no disability does he have any symptoms? • If Yes score 1 • If No score 0 mRS training is available at: http://rankin-english.trainingcampus.net/uas/modules/trees/windex.aspx If two options appear equally valid and if further questions are considered unlikely to clarify choice, then the more severe category should be selected.