National Stroke Audit 2024 - Rehabilitation Services

Clinical Audit Data Dictionary

Underpinning National Stroke Audit & the AuSDaT system is the National Stroke Data Dictionary (NSDD), which provides standardised definitions, coding and recording guidance for all data items collected in AuSDaT. It is regularly updated in alignment with current research and guidelines, please refer to the link below for most up-to-date version.

The National Stroke Data Dictionary for the clinical audit variables can be downloaded from: **http://australianstrokecoalition.com.au/ausdat/**

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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.

4.340 What date was the patient admitted to the inpatient rehabilitation facility?

Common Name	Inpatient rehabilitation admission date.
Definition	The date on which the patient was admitted to the rehabilitation facility as an inpatient.
Main Source of Standard	Definition Attributes: Clinical audit method – Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)

Format	User Interface: 4.340 Calendar
Recording Guidance	Individual patient medical records – Admission form and/or patient administration system.
Codes and Values	4.340 DD/MM/YYYY
Help Notes	Rehabilitation begins • when the patient is admitted to the rehabilitation unit; • and/or the care type is changed to rehabilitation no matter where the patient is physically located (rehabilitation ward, acute ward, ICU) ; • and/or the rehabilitation team forms part of a shared care arrangement (neurology specialist AND rehabilitation specialist) and the patient actively commences a rehabilitation program. If the accurate (exact) date is unknown or is undetermined the "Estimate" radio button, located below the entered date, should be selected.
Further Information	

4.660 Prior to rehabilitation, where has the patient come from?

Common Name	
Definition	This item captures information about where the patient came from when the episode started.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Drop down list
Recording Guidance	Individual patient medical records – Nursing notes and medical notes, allied health records, ward admission list
Codes and Values	SU = Stroke unit AIW = Acute inpatient ward ORW = Other rehabilitation ward GPR = General practitioner referral OTH = Other UNK = Unknown
Help Notes	The stroke unit/acute inpatient and rehabilitation wards may be at your hospital or another hospital.

	If you are unfamiliar with the ward or facility the patient has come from and cannot determine the type of ward from the name in the notes (e.g. Mackillop ward, 9 West), “Unknown” is to be selected.
Further Information	

4.670 Where was this patient treated during inpatient rehabilitation?
4.680 Other (specify)

Common Name	
Definition	Location of inpatient care episode specifically for rehabilitation.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Drop down list
Recording Guidance	Individual patient medical records – Allied health records, nursing notes and medical notes, ward admission list
Codes and Values	DSRU = Dedicated stroke rehabilitation unit; NU = Neurorehabilitation unit; CARU = Combined acute / rehabilitation stroke unit; MRW = Mixed rehabilitation ward OTH = Other
Help Notes	Stroke rehabilitation units provide rehabilitation care exclusively to individuals with stroke, once the person is no longer acutely ill after their stroke. DSRUs accept patients after a delay, usually of seven days or more, and focus on rehabilitation. Refer to stroke unit minimum criteria outlined in **Ref 4.380.** **Neurorehabilitation unit:** a multidisciplinary team including specialist nursing staff in a ward providing a specific neurorehabilitation service but not exclusively caring for stroke patients. **Mixed rehabilitation ward:** a multidisciplinary team including specialist nursing staff in a ward providing a generic rehabilitation service but not exclusively caring for stroke patients.

	‘Other’ includes hospital bed substitution models, for example, Early Supported Discharge (ESD), Rehabilitation in the Home (RITH) and Better@home.
Further Information	

Other clinical information

9.00 **On admission** were any of the following impairments present?

9.000 Sensory deficit
9.010 Cognitive deficit
9.020 Visual deficit
9.030 Perceptual deficit
9.040 Speech/communication impairment
9.050 Hydration problems
9.060 Nutrition problems
9.061 Arm deficit
9.062 Lower limb deficit
9.063 Dysphagia
9.064 Continence
9.065 Balance
9.066 Other
9.067 Other (specify)

Common Name	
Definition	Presence of arm impairments on admission to hospital
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013, Section F2.
Format	User Interface:

	9.000- 9.066 Radio buttons 9.067 Text box
Recording Guidance	Individual patient medical records – ED record/notes, ambulance report, admission notes, allied health records, nursing notes, medical notes.
Codes and Values	9.000- 9.066 1 = Yes 2 = No 9 = Not documented 9.067 Free text
Help Notes	Sensory deficit: Any impairment of the sensory system. Cognitive deficit: Any impairment of memory or higher executive functions including but not limited to: aphasia, acalculia, dysgraphia, left-right disorientation, finger agnosia. Visual deficit: Any deficit of the visual fields. Perceptual deficit: Any deficit of perception. Speech/communication impairment: Any form of expressive or receptive dysphasia or aphasia, verbal dyspraxia or dysarthria. Hydration problems: If an assessment of the patient's fluid status suggests they are dehydrated then this should be marked. Nutrition problems: 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. Arm deficit: Difficulty moving any part of the arm specifically due to the stroke e.g. hand, elbow, and/or shoulder. Lower limb deficit: Difficulty moving any part of the leg specifically due to the stroke e.g. foot, knee, or hip. Dysphagia: Any difficulty in swallowing function. Continence: Impairment of urinary and/or bowel functions.

	Balance: Impaired ability in balance either while sitting, standing, or walking. Other
Further Information	

Hydration & nutrition

9.220 Was a malnutrition screen performed?

Common Name	Malnutrition screening
Definition	Evidence that a validated tool was used to screen the patient for malnutrition.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)
Format	User Interface: Radio button
Recording Guidance	Patient medical records – allied health records, nursing notes and medical notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Screening should be undertaken using a validated nutrition screening tool e.g. Malnutrition Universal Screening Tool (MUST) or the Malnutrition Screening Tool (MST). BMI (Body Mass Index) is not a validated malnutrition screening tool, because it does not indicate if the patient is at risk of malnutrition. 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. This is a separate measure to a nutrition assessment. The two should not be confused.
Further Information	Indicator of risk of malnutrition

9.270 Was the patient at risk of malnutrition?

Common Name	
Definition	Evidence that the patient was at risk of malnutrition as diagnosed using a number of parameters including unintentional weight loss, decreased oral intake and evidence of muscle wasting/subcutaneous fat loss.
Main Source of Standard	Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records – allied health records, nursing notes and medical notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	The following terms may appear in the notes: • Poor/reduced oral intake noted in admission details • Recent weight loss • BMI >25 or < 18 • Low body weight • Overweight/obese • "Malnutrition/malnourished" recorded in admission details • MST (malnutrition screening tool): score of 2 or more • MNA (mini nutrition assessment) score of less than or equal to 23 • PG-SGA (patient generated subjective global assessment): score of B or C • SGA (subjective global assessment): score of B or C • High Alcohol use /abuse • Look for Vitamin or mineral deficiency (e.g B12 deficiency, iron, vit D)
Further Information	

Management included:

9.330 Ongoing monitoring by a dietitian

9.340 Nutritional supplementation for those whose nutritional status was poor or deteriorating
9.350 Alternative feeding
9.355 Type

Common Name	
Definition	Management strategies for those found to have nutrition problems.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records – Allied health records, Nursing notes and Medical notes
Codes and Values	9.330- 9.350 1 = Yes 2 = No 9.355 NGF = NG feeding PEG = PEG
Help Notes	Question enabled if "Yes" chosen for "Was a nutrition assessment by a dietician recorded?" (Ref 9.280) Tick all that apply Examples of nutrition support include: • Nutritional supplement drinks • Enteral feeding (Nasogastric or Percutaneous) • Total Parenteral Nutrition • High protein high energy food and drink items or fortified foods (e.g. extra oil or margarine to foods) If "Yes" to alterative feeding, then specify whether it was via nasogastric (NGF) feeding or percutaneous endoscopic gastrostomy (PEG)
Further Information	

Mobilisation

9.360 Was the patient able to walk independently on admission?

Common Name	Ability to walk independently on admission.
Definition	Ability to walk unaided or without any form of assistance, at the time of arrival to the hospital. 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.
Main Source of Standard	<u>Definition Attributes:</u> AuSCR Data Dictionaries (Version 3 March 2015) VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3 New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013 Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Validated prognostic variable originally from Counsell C, Dennis M, McDowall M, et al. Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. Stroke 2002; 33(4):1041-7
Format	User Interface: Radio buttons Import Template: Numeric field
Recording Guidance	Patient medical records – admission notes, ED notes, history and medical /nursing notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	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 to hospital. 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, walking 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
Further Information	This variable has been validated for use as a predictor of independence at time of hospital discharge (Cadilhac, 2010). Cadilhac D., Kilkenny M., Churilov L., et al. Identification of a reliable subset of process indicators for clinical audit in stroke care: an example from Australia. Clinical Audit 2010; 2: 67-77. Counsell C, Dennis M, McDowall M, et al. Predicting outcome after acute and subacute stroke: development and validation of new prognostic models. Stroke 2002; 33(4):1041-1047

Management included:

9.410 Tailored, repetitive practice of walking (or components of walking)
9.411 Circuit class therapy (with focus on overground walking practice)
9.412 Treadmill training with or without body weight support
9.450 Other therapy

Common Name	
Definition	Management strategies for those found to have mobilisation problems.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes
Codes and Values	1 = Yes 2 = No
Help Notes	9.411 and 9.412 enabled if ‘yes’ to 9.410 Please select ‘Other therapy’ for other management strategies used for example, virtual reality training, electromechanically assisted gait training, biofeedback, cueing of cadence, or orthotics
Further Information	

Arm deficit

9.460 Was the patient’s upper limb assessed?

Common Name	
Definition	Evidence that patient’s upper limb was assessed
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2015)

Format	User Interface: Radio button
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Review assessment documented by physiotherapist or occupational therapist. Assessment may include scales such as the Motor Assessment Scale (MAS), 9 hole peg test, or part of scales such as the Functional Independence Measure (FIM). Answer "Yes" if at least one part of arm function is assessed (proximal/shoulder or elbow movement and/or distal/hand or wrist movement).
Further Information	

Management included:

9.510 Constraint-induced movement therapy (in selected people)
9.520 Repetitive task-specific training
9.540 Other therapy

Common Name	Management of arm impairment.
Definition	Management strategies for those found to have difficulty using their upper limb.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - Allied health records, Nursing notes and Medical Notes
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if "Yes" to "Arm deficit on admission" (Ref 9.061) Please select 'Other therapy' for other management strategies used, for example, virtual reality training, mental practice, or mirror therapy.
Further Information	

Continence

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

Common Name	
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.
Main Source of Standard	<u>Definition Attributes:</u> Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Procedures for auditing medical records for stroke admissions using New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	[**Note**: this is a generic question, for purposes of the Rehabilitation Audit, please treat as 72 hours within admission to inpatient rehabilitation] 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.
Further Information	Urinary incontinence is a predictor of poorer outcomes after stroke.

9.611 Was the patient incontinent of urine during their rehabilitation care?

Common Name	Incontinent of urine during rehabilitation
Definition	Evidence that the patient was incontinent of urine during inpatient rehabilitation care.
Main Source of Standard	Representational Standard: Clinical audit method –Stroke Foundation’s National Stroke Audit Rehabilitation Services (2018)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Answer “Yes” if during inpatient rehabilitation, urinary incontinence was identified/confirmed. This includes all types of urinary incontinence (urge, retention, functional). Answer “Yes” if urinary catheter is used.
Further Information	

9.660 Was a urinary incontinence structured management plan documented?

Common Name	
Definition	A management plan documented for urinary incontinence.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013, Section H4.
Format	User Interface: Radio button
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	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.
Further Information	

Mood

9.740 Was the patient's mood assessed?

Common Name	
Definition	Evidence that patient's mood (state of mind or emotion) was assessed during this admission.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	
Further Information	Depression, anxiety and emotional lability are common after stroke and should be assessed and treated.

9.780 Did the patient have a mood impairment (depression, emotional lability or anxiety)?

Common Name	
Definition	Evidence that patient had any form of mood disturbance e.g. depression, emotional lability or anxiety.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)

	Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Question enabled if "Yes" answered to "Was the patient's mood assessed?" (Ref 9.740)
Further Information	

Management included:

9.790 Antidepressants
9.800 Psychological (e.g. Cognitive-behavioural) interventions
9.810 Other therapy
9.820 No therapy provided

Common Name	
Definition	Management strategies for those found to have a mood impairment.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if "Yes" answered to "Did the patient have a mood impairment?" (Ref 9.780) Select 'Other therapy' for other management strategies, for example, structured exercise program, non-invasive brain stimulation, or acupuncture. Tick all that apply.
Further Information	

ADL

9.830 Did the patient have difficulty with Activities of Daily Living (ADLs)?

Common Name	
Definition	Evidence that the patient had difficulty with activities of daily living (e.g. feeding, toileting, grooming, dressing, bathing, walking).
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Representational Standard: National Health Data Dictionary METeOR Identifier: 269825 Registration Status: Health, Standard 01/03/2005 http://meteor.aihw.gov.au/content/index.phtml/itemId/269825
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records – admission notes
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	ADLs refer to daily self care activities within an individual's place of residence, in outdoor environments, or both. They include feeding, toileting, grooming, dressing, bathing, walking.
Further Information	An indicator of a person's ability to carry out activities of daily living without assistance.

Management included:

9.840 Task specific practice
9.850 Trained use of appropriate aids
9.860 Other

Common Name	
Definition	Management strategies for those found to have difficulties with Activities of Daily Living.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if “Yes” answered to “Did the patient have difficulty with Activities of Daily Living on admission?” (Ref 9.830) Select ‘Other’, for other management strategies used, for example, virtual reality therapy. Look for evidence of assessment by a health professional and that the patient demonstrated difficulty with activities of daily living on examination.
Further Information	

Aphasia

9.870 Did the patient have aphasia?

Common Name	Aphasia, dysphasia (speech impairment)
Definition	Evidence that patient had aphasia, a common communication deficit following stroke.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented

Help Notes	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. Look for documentation from medical, nursing and allied health regarding communication issues.
Further Information	

Management included:

9.901 Speech and language therapy 2-3 days per week
9.910 Communication partner training provided to the primary communication partner of the person with aphasia
9.920 Delivery of therapy programs via computer
9.930 Group therapy (e.g. conversation groups)
9.940 Other therapy

Common Name	
Definition	Management strategies for those found to have aphasia.
Main Source of Standard	Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 3 = Declined 4 = No primary communication partner (9.910 only)
Help Notes	Question enabled if "Yes" answered to "Did the patient have aphasia?" (Ref 9.870)
Further Information	Impairment-based therapies are aimed at addressing all communication modalities, and consists of procedures/training in which the clinician directly stimulates those areas in which a person makes errors: specific listening, speaking, reading, and writing skills:

	• Constraint-induced language therapy • Melodic intonation therapy • Reading treatment • Syntax treatment • Treatment of underlying forms • Verb network strengthening treatment • Word finding treatment • Writing treatment Communication-based (activities/participation-based treatment) therapies are intended to enhance communication by any means and encourage support from caregivers; often consist of more natural interactions involving real life communicative challenges: • Multimodal treatment - including AAC, Visual Action Therapy, Promoting Aphasics' Communication Effectiveness (PACE), Oral Reading for Language in Aphasia (ORLA) • Partner approaches - including conversational coaching, Supported Communication Intervention (SCI), social and life participation Effectiveness • Pragmatic treatment • Reciprocal scaffolding • Script training Therapies can be provided face to face or via tele-rehabilitation where available.

Neglect

9.950 Did the patient have neglect/inattention?

Common Name	
Definition	Evidence that patient had neglect/inattention.
Main Source of Standard	Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons

Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Visual inattention is a common condition associated with stroke. Also known as ‘unilateral spatial neglect’, or more simply as ‘neglect’, it presents as a difficulty in detecting or acting upon information on one side of space.
Further Information	

Management included:

9.960 Visual scanning training with sensory stimulation
9.980 Eye patching
10.000 Mental practice
10.010 Other therapy

Common Name	
Definition	Management strategies for those found to have neglect/inattention.
Main Source of Standard	Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, observation chart
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if “Yes” answered to “Did the patient have neglect/inattention?” (Ref 9.950) Select ‘Other therapy’ for other management strategies used, for example, mirror therapy.
Further Information	

Early outcome measures

10.310 First known modified Rankin Scale (within 72 hours of admission to rehabilitation)

10.320 Unknown/derive
10.330 Is the patient alive?
10.340 Can the patient walk on their own (i.e. without the assistance of another person, but may include walking aid)?
10.350 If the patient cannot walk on their own can they walk if someone is helping them?
10.360 If the patient can walk on their own (includes walking aids) do they help with simple usual personal activities (toilet, bathing, dressing, cooking, household tasks, simple finances)?
10.370 If the patient can perform simple personal activities, do they need help with more complex usual activities (driving, golf, finances, household bills, work tasks)?
10.380 If the patient has no disability, do they have any symptoms?

Common Name	
Definition	Patient's modified Rankin scale score (0-6) within 72 hours of admission
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.310 Drop down list 10.320 Tick box 10.330- 10.380 Radio buttons
Recording Guidance	Patient medical records – nursing notes, medical notes, allied health notes If not documented, can be calculated using algorithm.
Codes and Values	10.310 Numerical 0-6 10.320 TRUE FALSE 10.330- 10.380 1 = Yes

	2 = No
Help Notes	If mRS is known, enter 0-6 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 6: Dead If unknown, calculate using following algorithm a. Is the patient alive? • If Yes got to question b • If No score 6 b. Can the patient walk on their own? • If No go to question c • If Yes go to question d c. 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 d. 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 e e. If the patient 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 f f. If the patient 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.
Further Information	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.

10.390 Total Motor FIM score on admission
10.400 Unknown

Common Name	
Definition	An assessment of the severity of a patient's physical disability on admission.
Main Source of Standard	Definition Attributes Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Representational Standard: National Health Data Dictionary METeOR Identifier: 495857 Registration Status: Health, Standard 11/04/2014 http://meteor.aihw.gov.au/content/index.phtml/itemId/495857
Format	User Interface: 10.390 Drop down list 10.400 Tick box
Recording Guidance	Patient medical records – admission notes, ED report, nursing notes, medical notes, allied health notes
Codes and Values	10.390 Numerical (13-91) 10.400 TRUE FALSE

Help Notes	The Functional Independence Measure (FIM™) instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care. The motor subscale includes: • Eating • Grooming • Bathing • Dressing, upper body • Dressing, lower body • Toileting • Bladder management • Bowel management • Transfers - bed/chair/wheelchair • Transfers - toilet • Transfers - bath/shower • Walk/wheelchair • Stairs Admission FIM scoring needs to be completed within 72 hours of patient admission. Only numbers between 13 and 91 are accepted.
Further Information	

10.410 Total Cognitive FIM score on admission
10.420 Unknown

Common Name	Cognitive FIM on admission
Definition	An assessment of the severity of a patient's cognitive disability on admission.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)

	Representational Standard: National Health Data Dictionary METeOR Identifier: 495857 Registration Status: Health, Standard 11/04/2014 http://meteor.aihw.gov.au/content/index.phtml/itemId/495857
Format	User Interface: 10.410 Drop down list 10.420 Tick box
Recording Guidance	Individual patient medical records – admission notes, ED report, nursing notes, medical notes, allied health notes
Codes and Values	10.410 Numerical (5- 35) 10.420 TRUE FALSE
Help Notes	The Functional Independence Measure (FIM™) instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care. The cognition subscale includes: • Comprehension • Expression • Social interaction • Problem solving • Memory Admission FIM scoring needs to be completed within 72 hours of patient admission. Only numbers between 5 and 35 are accepted.
Further Information	

Communication and support for patient and family/carer

10.760 Were goals set with input from the team and patient (or family alone if patient has severe aphasia or cognitive impairments)?

Common Name	
Definition	Evidence that goals were set within input from both the patient and the multidisciplinary team.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No
Help Notes	Goal-setting must have involved both the patient and the multidisciplinary team. 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 "Yes" is the most appropriate response.
Further Information	Goal-setting is a fundamental process of rehabilitation that enables interdisciplinary teamwork, motivates clients and provides a measure of evaluating patient progress.

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

Common Name	
Definition	Evidence that information covering stroke, hospital management, secondary prevention and recovery was provided to patient and/or family.
Main Source of Standard	Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented

Help Notes	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.
Further Information	

10.830 Does the patient have a carer?

Common Name	
Definition	Evidence that patient has a carer i.e. an individual that assists the stroke survivor with day to day activities without whom they would not be able to cope at home.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes, medical notes, discharge summary
Codes and Values	1 = Yes 2 = No NR = Not required
Help Notes	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.
Further Information	An indicator that the stroke survivor needs assistance for activities of daily living.

10.840 Did the carer receive relevant carer training?

Common Name	
Definition	Training provided to the patient's carer on specific needs the patients will have when returning home.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 10.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes, medical notes, discharge summary
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if "Yes" answered to "Does the patient have a carer?" (Ref 10.830) Look for written evidence that the carer was trained in methods relevant to care in the community. For example transfers, pressure care etc.
Further Information	

10.841 If no, select reason

Common Name	
Definition	Reason carer did not receive relevant carer training
Main Source of Standard	Definition Attributes: Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 10. Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Patient transferred to inpatient rehab or other acute care 2 = Carer declined 3 = Other
Help Notes	Question enabled if "No" selected for "Did the carer receive relevant carer training?" (Ref 10.840)

Further Information	

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

Common Name	
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.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 10.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes, medical notes, discharge summary
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if "Yes" answered to "Does the patient have a carer?" (Ref 10.830)
Further Information	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

Common Name	
Definition	Reason carer did not receive a support needs assessment.
Main Source of Standard	Definition Attributes: Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 10.
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Patient transferred to inpatient rehab or other acute care

	2 = Carer declined 3 = Other
Help Notes	Question enabled if “No” selected for “Did the carer receive a support needs assessment?” (Ref 10.850)
Further Information	

10.860 Was the carer provided with information about peer support resources prior to patient's discharge? (Yes / No / Not documented)

Common Name	
Definition	Written evidence that the carer was provided with information about peer support resources prior to patient’s discharge.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes, medical notes, discharge summary
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Question enabled if “Yes” answered to “Does the patient have a carer?” (Ref 10.830) If there is documented evidence that the issue was raised with the carer and the carer refused information then “Yes” may still be selected, as an attempt to deliver this process of care has been made.
Further Information	An indicator of post-discharge support for the carer.

Allied health management

10.450 Was the patient seen by a physiotherapist?

Common Name	
Definition	First assessment by a physiotherapist
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017)

	Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
Help Notes	“Therapist not 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.
Further Information	

10.460 Date
10.470 Unknown

Common Name	
Definition	Date and time of first physiotherapist assessment
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.460 Calendar field 10.470 Tick boxes
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	10.460 DD/MM/YYYY 10.470 TRUE FALSE
Help Notes	Question enabled if “Yes” selected for “Was the patient seen by Physiotherapist?” (Ref 10.450) Answer “Unknown” if date/time of assessment not documented in patient notes.

Further Information	

10.500 Was the patient seen by an occupational therapist?

Common Name	
Definition	First assessment by an occupational therapist
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
Help Notes	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.
Further Information	

10.510 Date
10.520 Unknown

Common Name	
Definition	Date and time of occupational therapist assessment
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)

	Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.510 Calendar field 10.520 Tick boxes
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	10.510 DD/MM/YYYY 10.520 TRUE FALSE
Help Notes	Question enabled if "Yes" selected for "Was the patient seen by an occupational therapist?" (Ref 10.500). Answer "Unknown" if date and/or time of assessment not documented in patient notes.
Further Information	

10.550 Was the patient seen by a speech pathologist?

Common Name	
Definition	First assessment by Speech Pathologist
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
Help Notes	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.
Further Information	

10.560 Date
10.570 Unknown

Common Name	
Definition	Date and time of first speech and language therapist assessment.
Main Source of Standard	<u>Definition Attributes:</u> Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.560 Calendar field 10.570 Tick boxes
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	10.560 DD/MM/YYYY 10.570 TRUE FALSE
Help Notes	Question enabled if "Yes" selected for "Was the patient seen by speech pathologist?" (Ref 10.550) Answer "Unknown" if date and/or time of assessment not documented in patient notes.
Further Information	

10.600 Was the patient seen by a social worker?

10.600	
Common Name	
Definition	First assessment by social worker.
Main Source of Standard	<u>Definition Attributes:</u>

	Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
Help Notes	"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.
Further Information	

10.610 Date
10.620 Unknown

Common Name	
Definition	Date/time patient was first seen by social worker.
Main Source of Standard	<u>Definition Attributes:</u> Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.610 Calendar field 10.620 Tick boxes
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	10.610 DD/MM/YYYY 10.620 TRUE FALSE

Help Notes	Question enabled if “Yes” selected for “Was the patient seen by social worker?” (Ref 10.600) Answer “Unknown” if date and/or time of assessment not documented in patient notes.
Further Information	

10.650 Was the patient seen by a dietitian?

Common Name	
Definition	First assessment by a dietitian.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff
Help Notes	“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.
Further Information	

10.660 Date
10.670 Unknown

Common Name	

Definition	Date/time patient was first seen by dietitian.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.660 Calendar field 10.670 Tick boxes
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	10.660 DD/MM/YYYY 10.670 TRUE FALSE
Help Notes	Question enabled if "Yes" selected for "Was the patient seen by dietitian?" (Ref 10.650) Answer "Unknown" if date and/or time of assessment not documented in patient notes.
Further Information	

10.700 Was the patient seen by a psychologist?

10.700	
Common Name	
Definition	First assessment by a psychologist.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No NR = Not required D = Patient declined NT = Therapist not on staff

Help Notes	“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.
Further Information	

10.710 Date
10.720 Unknown

Common Name	
Definition	Date/time patient was first seen by a psychologist.
Main Source of Standard	<u>Definition Attributes:</u> Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 10.710 Calendar field 10.720 Tick boxes
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	10.710 DD/MM/YYYY 10.720 TRUE FALSE
Help Notes	Question enabled if “Yes” selected for “Was the patient seen by psychologist?” (Ref 10.700) Answer “Unknown” if date and/or time of assessment not documented in patient notes.
Further Information	

Complication during hospital admissions

Did the patient have any of the following complications **<u>during their admission</u>** to rehabilitation?

11.160 Aspiration pneumonia
11.170 Deep Vein Thrombosis (DVT)
11.180 Falls
11.190 Fever
11.200 Pressure sores e.g. decubitus ulcer
11.230 Shoulder pain
11.240 Shoulder subluxation
11.280 Malnutrition
11.290 New onset atrial fibrillation
11.320 Urinary tract infection
11.350 Contracture

Common Name	
Definition	Complications documented while the patient was in hospital.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013, Section I.
Format	User Interface: 11.160 - 11.350 Radio buttons
Recording Guidance	Individual patient medical records - Allied health records, nursing notes, medical notes, discharge summary
Codes and Values	11.160 – 11.350 1 = Yes 2 = No
Help Notes	Answer "Yes" to all complications that were documented on admission. If a complication is not listed, select "Other" and provide details. Aspiration Pneumonia - A working diagnosis of aspiration pneumonia is sufficient to tick "Yes". 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.

	Falls – Any fall in hospital. Fever - Two recorded temps above 38.5 in the first few days. Pressure sores – Other names for this type of damage include bed sores, pressure ulcers and decubiti ('lying down') ulcers. Shoulder pain - Shoulder pain after stroke is common and disabling. Shoulder subluxation - known as shoulder instability and may result in the upper arm bone (humerus) moving partially or completely out of the socket during certain arm movements. Malnutrition - some words to be aware of: • MST (malnutrition screening tool): score of 2 or more. • MNA (mini nutrition assessment) score of less than or equal to 23. • PG-SGA (patient generated subjective global assessment): score of B or C. • SGA (subjective global assessment): score of B or C. • Poor/reduced oral intake noted in admission details. • “Malnutrition/malnourished” recorded in patient progress notes. • Recent weight loss. New onset atrial fibrillation – 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). Urinary tract infection (UTI) - Use MSU result or patient started antibiotics commonly used for UTI’s (Augmentin, Bactrim) as a “Yes”. Contracture - a permanent shortening of a muscle or joint.
Further Information	

Further rehabilitation and community re-integration

12.040 Was a referral made to rehabilitation?

Common Name	
Definition	Evidence that patient was referred to rehabilitation services.
Main Source of Standard	Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Individual patient medical records - allied health records, nursing notes, medical notes, discharge summary
Codes and Values	1 = Yes 2 = No 9 = Unknown
Help Notes	Question enabled if "Yes" answered to "Did the assessment identify the need for ongoing rehab?" (Ref 12.030) [Note: this is a generic question; for the purposes of the Rehabilitation Audit, please treat as referral to further rehabilitation on discharge]
Further Information	

12.051 If yes, Type:
12.06 Other [Specify]

Common Name	Rehab location
Definition	Location where ongoing rehabilitation will be delivered.
Main Source of Standard	Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: 12.051 Drop down list 12.060 Text box
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	IR = Inpatient rehabilitation SNAP = Inpatient rehabilitation within ASU OR = Outpatient rehabilitation

	CRH = Community rehabilitation home based CRD = Community rehabilitation day hospital ESD = Early supported discharge service GEM = GEM rehab TC= Transition care residential TC= Transition care community IH = Individual home based IC = Individual centre based OTH = Other 12.06 Free text
Help Notes	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 accessed after inpatient rehabilitation (and so not to be confused with ESD) **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 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). **Geriatric Evaluation and Management (GEM)** - inpatient care is provided but is more around assessment than active rehabilitation

	Transition care residential – restorative care providing support to patients for up to 12 weeks in a residential care setting where they are recovering from a hospital stay **Transition care community** – restorative care providing support to patients for up to 12 weeks in their own home where they are recovering from a hospital stay **Individual home based** – usually single discipline as opposed to a multidisciplinary program, with the therapist attending the patient's home **Individual centre based** – usually single discipline as opposed to a multidisciplinary program, with the patient attending a centre for therapy **Other** – specify the type of service if not included in the list
Further Information	

12.190 Was the patient asked if they wanted to return to driving?

Common Name	
Definition	Evidence that patient was asked if they wanted to return to driving
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	Select "Not documented" if there is no evidence that the patient was asked about their wish to return to driving.
Further Information	An indicator of a person's desire to return to driving.

12.191 Reason (if ' no')

Common Name	
Definition	Reason why patient was not asked if they wanted to return to driving.
Main Source of Standard	Representational Standard: Clinical audit method –Stroke Foundation's National Stroke Audit Rehabilitation Services (2018)
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	DND = Did not drive prior to the stroke PIP = Patient too ill to participate SCI = Severe cognitive impairment OT = Other
Help Notes	Question enabled if "No" answered to "Was the patient asked if they wanted to return to driving?" (Ref 12.190) Answer the most appropriate reason even if there is more than one reason. "Did not drive prior to stroke" refers to the period (months) prior to stroke even if they had driven in the past (e.g. 80 years old and no longer drives but did earlier in life).
Further Information	

12.200 Did the patient want to return to driving?

Common Name	
Definition	Patient indication that they wished to return to driving.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No
Help Notes	Question enabled if "Yes" answered for "Was the patient asked if they wanted to return to driving?" (Ref 12.190)
Further Information	

12.220 Was the patient provided with information about the process to return to driving?

Common Name	
Definition	Provision of information to patient about the process to return to driving.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	
Further Information	

12.230 Was the patient referred for driving assessment?

Common Name	
Definition	Evidence that the patient was referred for a driving assessment.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	
Further Information	

12.231 Was the patient employed before the stroke onset?

Common Name	
Definition	Evidence that the patient was employed prior to the stroke onset
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2014)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	
Further Information	

12.240 Was the patient asked if they wanted to return to work?

Common Name	
Definition	Evidence that the patient was asked if they wanted to return to work.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2014)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	
Further Information	

12.250 Did the patient want to return to work?

Common Name	

Definition	Patient indication that they wished to return to work.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No
Help Notes	
Further Information	

12.260 Was the patient informed of services to assist with return to work?

Common Name	
Definition	Provision of information of services to assist patient with return to work.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 9 = Not documented
Help Notes	
Further Information	

With regard to sexuality, was the patient offered:

12.270 The opportunity to discuss issues relating to sexuality?
12.280 Written information addressing issues relating to sexuality post stroke?

Common Name	
Definition	Evidence that the patient was offered: a) The opportunity to discuss issues relating to sexuality b) Written information addressing issues relating to sexuality post stroke
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No
Help Notes	Assumptions on the "appropriateness" of providing information on sexuality based on age, widowed status etc are not sufficient reason to not provide this information. Consumer-based research described negative impact on the sex life of almost half of the survey respondents. This is a very important issue that cannot be ignored, and stroke survivors should be provided an opportunity to speak with a relevant health professional or offered written material if the person would prefer.
Further Information	An indicator of the delivery of appropriate information relating to sexuality to people affected by stroke.

12.290 Was the patient provided with information about peer support (e.g. availability and benefits of local stroke support groups or another online peer support)?

Common Name	
Definition	Provision of information to patient about peer support (e.g. availability and benefits of local stroke support groups or other sources of peer support such as the Stroke Foundation's EnableMe website).
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation Audit of Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No

	9 = Not documented
Help Notes	EnableMe is a website created specifically for the Australian stroke community, owned and managed by the Stroke Foundation.
Further Information	

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".

13.001 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 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 (or family alone if patient has severe aphasia or cognitive impairments)?

Common Name	Smoking cessation advice for current and recently quit smokers
Definition	Evidence that patient was provided with smoking cessation advice if a current or recently quit smoker.
Main Source of Standard	Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2023)
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - allied health records, nursing notes and medical notes.
Codes and Values	1 = Yes 2 = No 3 = Not applicable (non-smoker) 4 = Not documented
Help Notes	
Further Information	

Medication prescribed on discharge

13.020 On discharge was the patient prescribed antithrombotics?

Common Name	Prescription of antithrombotic medication at discharge
Definition	Evidence that antithrombotic medication was prescribed at discharge. Antithrombotic medication includes both antiplatelet and anticoagulant medications.
Main Source of Standard	Definition Attributes: National Stroke Foundation: Clinical Guidelines for Stroke Management 2010 Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) AuSCR Data Dictionary (Version 3 March 2015 - Qld) SITS Registry data form for IVTP—standard 2014, Section 7.4.

	Registry of the Canadian Stroke Network Phase 4 Version 4.0 June 9, 2008 Riks-Stroke, Acute Phase. Version 8.0 (1 January, 2007)
Format	User Interface: Radio buttons Import Template: Numeric field
Recording Guidance	Patient medical records – medical notes, medication chart, and discharge summary.
Codes and Values	1 = Yes 2 = No 3 = Contraindicated 9 = Unknown
Help Notes	Select "Yes" if the patient was prescribed an antithrombotic agent on discharge from their acute episode of care. This is irrespective of discharge destination. Note: most programs relate to the acute episode of care, however, this item may also be applied to a post-acute episode of care e.g. national stroke audit rehabilitation care. In this case select "Yes" if prescribed prior to discharge from inpatient rehabilitation 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" if it is unclear whether an antithrombotic agent was prescribed on discharge.

Further Information	Antiplatelet medications include (but are not limited to) aspirin, clopidogrel, prasugrel, ticagrelor and dipyridamole. Anticoagulants include warfarin, apixaban, digabatran, rivaroxaban, unfractionated heparin, and low molecular weight heparins such as enoxaparin. Refer to MIMS for a full list.

13.110 If no, select reason:

Common Name	
Definition	Reason why antithrombotic medication was not prescribed at discharge.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 9.
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - nursing notes, medical notes, and discharge summary
Codes and Values	PR = Patient refused UR = Under review TF = Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway) NR = No reason given
Help Notes	Question enabled if "No" selected for "On discharge was the patient prescribed antithrombotics?" (Ref 13.020)
Further Information	

13.111 On discharge was the patient with ischaemic stroke and atrial fibrillation prescribed oral anticoagulation therapy?

Common Name	Patient with ischemic stroke and atrial fibrillation prescribed oral anticoagulant on discharge
Definition	Evidence that patient with ischemic stroke and atrial fibrillation was prescribed oral anticoagulation on discharge
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2023)
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - nursing notes, medical notes and discharge summary.

Codes and Values	1 = Yes 2 = No 9 = Unknown 3 = Contraindicated NA = Not applicable
Help Notes	Enabled when stroke type = ischemic (Ref 7.550) Not applicable if no AF present and/or not ischaemic stroke.
Further Information	

13.120 On discharge was the patient prescribed antihypertensives?

Common Name	Prescription of antihypertensive medication at discharge.
Definition	Evidence that patient was discharged on antihypertensive medication.
Main Source of Standard	Definition Attributes: National Stroke Foundation: Clinical Guidelines for Stroke Management 2010 Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) AuSCR Data Dictionaries (Version 3 March 2015) VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3 SITS Registry data form for IVTP—standard 2014 Riks-Stroke, Acute Phase. Version 8.0 (1 January, 2007) VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3, Section 10.6.
Format	User Interface: Drop down list Import Template: Numeric field
Recording Guidance	Patient medical records - nursing notes, medical notes, and discharge summary
Codes and Values	1 = Yes 2 = No 3 = Contraindicated 9 = Unknown
Help Notes	Select "Yes" if the patient was prescribed an antihypertensive agent on discharge from their current episode of care. This is irrespective of discharge destination. Note: most programs relate to the acute episode of care, however, this

	item may also be applied to a post-acute episode of care e.g. national stroke audit rehabilitation care. In this case select "Yes" if prescribed prior to discharge from inpatient rehabilitation 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".
Further Information	Antihypertensive medications 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 medications include alpha blockers (e.g. Prazosin), beta blockers (e.g. Atenolol, Metoprolol), calcium channel blockers (e.g. Amlodipine, Diltiazem hydrochloride) and thiazide diuretics. Refer to MIMs for full list.

13.200 If no, select reason:

Common Name	
Definition	Reason why antihypertensive agents were not prescribed at discharge.
Main Source of Standard	<u>Definition Attributes:</u> Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - Nursing notes, medical notes and discharge summary.
Codes and Values	PR = Patient refused UR = Under review TF = Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway) NR = No reason given
Help Notes	Question enabled if "No" selected for "On discharge was the patient prescribed antihypertensives?" (13.120)

Further Information	

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

Common Name	Prescription of lipid lowering medication at discharge.
Definition	Evidence that patient was discharged on lipid lowering treatment
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation’s National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation’s National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons Import Template: Numeric field
Recording Guidance	Patient medical records - nursing notes, medical notes, and discharge summary
Codes and Values	1 = Yes 2 = No 9 = Unknown 3 = Contraindicated
Help Notes	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. Note: most programs relate to the acute episode of care, however, this item may also be applied to a post-acute episode of care e.g. national stroke audit rehabilitation care. In this case select “Yes” if prescribed prior to discharge from inpatient rehabilitation 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”.

Further Information	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:

Common Name	
Definition	Reason why lipid lowering treatment was not prescribed at discharge.
Main Source of Standard	Definition Attributes: Australian Commission on Safety and Quality in Health Care. Indicator Specification: Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 28. Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)
Format	User Interface: Drop down list
Recording Guidance	Patient medical records - nursing notes, medical notes and discharge summary.
Codes and Values	PR = Patient refused UR = Under review TF = Treatment was futile (i.e. advance care directive is enacted/ the patient is on a palliative care pathway) NR = No reason given
Help Notes	Question enabled if "No" selected for "On discharge was the patient prescribed lipid lowering treatment?" (Ref 13.210)
Further Information	

Discharge information

14.080 Date of discharge

Common Name	Date of discharge from current episode of care.
Definition	The date the patient was discharged (and accuracy) from current episode of care.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)

	Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) AuSCR Data Dictionaries (Version 3 March 2015) INSPIRE clinical data guidance version 9, pg 13. SITS Registry data form for IVTP—standard 2014, Section 7.2. Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008) <u>Representational Standard:</u> National Health Data Dictionary METeOR Identifier: 270160 Registration Status: Community Services, Standard 01/03/2005 http://meteor.aihw.gov.au/content/index.phtml/itemId/270160
Format	User Interface: 14.080 Calendar field. 14.090 Radio buttons. Import Template: 14.080 Date field. 14.090 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	Patient medical records - discharge summary If "Yes" is selected for "is the date of discharge known" (Ref 14.070) then these date and accuracy details will be enabled. Conversely, date and accuracy details are greyed out and disabled if "No" is selected.
Codes and Values	14.080 DD/MM/YYYY 14.090 AAA Accurate EAA Estimate
Help Notes	If the date of discharge is unclear then record an estimated date of discharge and identify as "Estimate". The discharge date should reflect their entire rehabilitation admission, including any suspensions
Further Information	

14.150 What is the discharge ICD 10 Classification Code?

Common Name	Principal diagnosis ICD-10-AM on discharge.
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). Principal diagnoses are classified according to the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM.*
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) AuSCR Data Dictionaries (Version 3 March 2015) VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3. SITS Registry data form for IVTP—standard 2014 Section 9.2. New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013 Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008) AIHW website (http://www.aihw.gov.au/hospitals-data/principal-diagnosis-data-cubes/) Representational Standard: National Health Data Dictionary METeOR Identifier: 640978 Registration Status: Health, Standard 05/10/2016 http://meteor.aihw.gov.au/content/index.phtml/itemId/640978
Format	User Interface: 14.150 Drop down list. 14.151 Alpha numeric field. Text box. Maximum character length: 6. Import Template: 14.150 Alpha numeric field. Case sensitive – use upper case. 14.151 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	Patient medical records - discharge summary
Codes and Values	14.150 I61.0 – I61.6, I61.8, I61.9 I62.9

	I63.0 – I63.6, I63.8, I63.9 I64.0 G45.9 OTH = Other 14.151 Free text
Help Notes	See Appendix 3 for full description of codes listed above. ICD-10-AM diagnosis codes are assigned to patient records after discharge by Health Information staff and should not be coded by those responsible for data collection/entry at your hospital. The delay in coding by your hospital will influence when the ICD-10AM codes can be entered. The principal diagnosis on discharge should be entered in this field. The principal diagnosis on discharge will not always be coded as a stroke or TIA. If the principal diagnosis is not one of the listed codes then "Other" should be recorded. If "Other" is selected the code should be specified in 14.151. If you are unable to locate a principal diagnosis on discharge then leave this field blank, until coding is completed by Health Information Services staff.
Further Information	The principal diagnosis is one of the most valuable health data elements. It is used for epidemiological research, case mix studies and health care planning purposes. Therefore, these codes are important for international, national or state-based comparative analyses of stroke separations.

14.160 What is the discharge destination/mode?

Common Name	Discharge destination
Definition	Separation of person and place to which person is released (discharge/transfer/death) as represented by a code.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) AuSCR Data Dictionaries (Version 3 March 2015) Data Elements for Paul Coverdell National Acute Stroke Registry (January 16, 2008)

	VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3, Section 10.4. SITS Registry data form for IVTP—standard 2014 Section 7.2 Representational Standard: National Health Data Dictionary METeOR Identifier: 270094 Registration Status: Health, Standard 01/03/2005 http://meteor.aihw.gov.au/content/index.phtml/itemId/270094
Format	User Interface: 14.160 Drop down list. 14.161 Radio buttons. Import template: 14.160 Numeric field. 14.161 Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	Patient medical record - physician's notes, nursing progress notes and social worker notes, discharge summary, discharge care plan. 14.160 If "Yes" has been selected for "Patient deceased during hospital care" (Ref 14.000) this variable will be autocompleted with "Died" and disabled (greyed out and disabled). 14.161 If "Discharge/transfer to a residential aged care service" is selected for "What is the discharge destination/mode", this field will be enabled. For the purpose of importing, leave field blank, unless "Discharge/transfer to a residential aged care service" was selected for "What is the discharge destination/mode".
Codes and 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
Help Notes	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.
Further Information	

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

Common Name	Discharge care plan.
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 •
Main Source of Standard	Definition Attributes: Australian Commission on Safety and Quality in Health Care. Indicator Specification: Acute Stroke Clinical Care Standard. Sydney: ACSQHC, 2015, pg 34. Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Core data elements 12.12 of the Paul Coverdell National Acute Stroke Registry (January 16, 2008) Procedures for auditing medical records for stroke admissions using) VST Victorian Stroke Telemedicine (VST) Program: Data Dictionary, November 2014, Version 1.3, Section 10.7. AuSCR Data Dictionaries (Version 3 March 2015) New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013 Section H6 (see also Procedures for auditing medical records for stroke admissions using New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013 pg. 8).
Format	User Interface: 14.190 Drop down list

	14.200- 14.201 Radio buttons Import Template: Alpha numeric field. Case sensitive – use upper case.
Recording Guidance	Patient medical records – patient history, discharge summary, discharge care plan Compliance with this indicator requires documented evidence of a care plan having been provided to any patient who is going home or to a non-medical private setting. Select "Not applicable" for patients who remain in a hospital setting (e.g. transferred to inpatient rehabilitation or other acute hospitals)
Codes and 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
Help Notes	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. .
Further Information	Consistent with Core data elements 12.12 of the Paul Coverdell National Acute Stroke Registry (January 16, 2008)

14.210 Is there evidence that the general practitioner and or community providers were provided with a copy of the discharge summary?

Common Name	
Definition	Evidence that the patient's general practitioner and/or community providers were provided with a copy of the discharge summary
Main Source of Standard	Definition Attributes:

	Clinical audit method - - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio button
Recording Guidance	Patient medical records – discharge summary
Codes and Values	1 = Yes 2 = No NA = Not applicable
Help Notes	A record that the discharge summary has been sent is sufficient for a "Yes" response. "Not applicable" can be answered if the patient is continuing rehabilitation as an inpatient.
Further Information	An indicator that the primary care practitioner has been informed of important information from the patient's recent hospital admission and discharge medications.

14.220 Was a home environment assessment carried out?

Common Name	Home assessment
Definition	Evidence that a review of the person's home was completed, considering factors such as environmental barriers, specific physical and/or cognitive impairments, and risk of falls.
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records – discharge summary
Codes and Values	1 = Yes 2 = No NR = Not required
Help Notes	Where clear documentation that a home visit was not required please select "Not required".
Further Information	Relevant to discharge planning and to decrease readmission rate.

14.240 Did the patient receive the contact details of someone in the hospital for any post-discharge questions?

Common Name	
Definition	Evidence that the patient was provided with a named contact in the hospital for post-discharge questions
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017) Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016)
Format	User Interface: Radio buttons
Recording Guidance	Patient medical records – discharge summary
Codes and Values	1 = Yes 2 = No NB = No but provided to family
Help Notes	"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. Examples of a contact are stroke liaison nurse, stroke support group representative. Post discharge questions might concern outpatient's appointments, stroke support groups, rehabilitation physician appointments, maintenance exercise groups, outpatient rehabilitation appointments, neurology appointments, or secondary prevention appointments.
Further Information	

Dependency on discharge

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

14.260 Unknown/Derive
14.265 Is the patient alive?
14.270 Can the patient walk on their own (i.e. without the assistance of another person, but may include walking aid)?
14.280 If the patient cannot 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 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?

Common Name	
Definition	Patient's modified Rankin Scale (0- 6) score at discharge
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Acute Services (2017)Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) AuSCR Data Dictionaries (Version 3 March 2015) New South Wales Stroke Care Audit Tool – National Stroke Research Institute – Version 1.3 2013, Section J1. INSPIRE clinical data guidance version 9 SITS Registry data form for IVTP—standard 2014, Section 7.8.
Format	Free text: Score (numerical 0-6) Radio buttons: Unknown/derive Radio buttons (algorithm if mRS is unknown)
Recording Guidance	
Codes and Values	User Interface: 14.250 Drop down list 14.260 Tick box 14.265- 14.310 Radio buttons
Help Notes	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.
Further Information	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.

14.340 Total Motor FIM score on discharge
14.350 Unknown

Common Name	
Definition	An assessment of the severity of a patient's physical disability on discharge.
Main Source of Standard	Definition Attributes Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Representational Standard: National Health Data Dictionary METeOR Identifier: 495857 Registration Status: Health, Standard 11/04/2014 http://meteor.aihw.gov.au/content/index.phtml/itemId/495857
Format	User Interface: 14.340 Free text 14.350 Tick box
Recording Guidance	Check patient notes for the patient's Total Motor FIM score assessed at the time of admission.
Codes and Values	14.340 Numerical (13- 91) 14.350 TRUE FALSE
Help Notes	The Functional Independence Measure (FIM™) instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care. The motor subscale includes: • Eating • Grooming • Bathing • Dressing, upper body • Dressing, lower body • Toileting • Bladder management • Bowel management • Transfers - bed/chair/wheelchair

	• Transfers - toilet • Transfers - bath/shower • Walk/wheelchair • Stairs
Further Information	

14.360 Total Cognitive FIM score on discharge
14.370 Unknown

Common Name	
Definition	An assessment of the severity of a patient's cognitive disability on discharge
Main Source of Standard	Definition Attributes: Clinical audit method - Stroke Foundation's National Stroke Audit Rehabilitation Services (2016) Representational Standard: National Health Data Dictionary METeOR Identifier: 495857 Registration Status: Health, Standard 11/04/2014 http://meteor.aihw.gov.au/content/index.phtml/itemId/495857
Format	User Interface 14.360 Free text 14.370 Tick box
Recording Guidance	Check patient notes for the patient's Total Cognitive FIM score assessed at the time of discharge.
Codes and Values	14.360 Numerical (5-35) 14.370 TRUE FALSE
Help Notes	The Functional Independence Measure (FIM™) instrument is a basic indicator of patient disability. FIM™ is used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care. The cognition subscale includes:

	• Comprehension • Expression • Social interaction • Problem solving • Memory
Further Information	

Thank you for your time and effort completing the National Stroke Rehabilitation Audit.