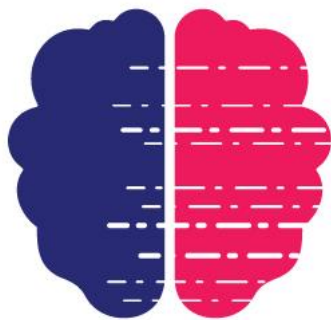


AuSCR Hospital User Manual



**AUSTRALIAN STROKE
CLINICAL REGISTRY**
FACILITATING QUALITY

September 2025

Version 1.6

CONTACT DETAILS

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UPDATES TO VERSION 1.6 – SEPT 2025 FROM VERSION 1.5 – SEPT 2021

Section	Updates in Version 1.6, September 2026	Page number(s)
Password and login	Added details on Multi-Factor Authentication	9

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INTRODUCTION

This user manual is designed as a guide for hospital staff to access and collect data for the Australian Stroke Clinical Registry (AuSCR) via the Australian Stroke Data Tool (AuSDaT). The AuSDaT has been specifically built to make data collection easier and more efficient. Each hospital staff member accessing the AuSCR will be provided with an AuSDaT username and password, which should not be shared with anyone else.

This manual will guide staff through acute data collection and will outline other user options, such as printing hospital reports and exporting your hospital's data from AuSCR. Users are assumed to have a basic level of computer skills and be familiar with browsing the internet.

All first-time users are encouraged to undertake initial AuSCR training. This can be arranged through your AuSCR state coordinators. This training provides an overview of the AuSCR and includes information on its purpose, governance structure, data collection, use of the AuSDaT, and the benefits of participating in AuSCR. The AuSCR team is able to provide additional education via teleconference, videoconference or face-to-face, on request. Additional training resources such as videos and frequently asked questions can be accessed by clicking on the "AuSCR Resources" button on the [AuSCR website](#). The password for entering this section of the website is "auscrhospital" (one word, all lower case).

Should you require any assistance, please don't hesitate to contact the AuSCR team via admin@auscr.com.au or visit our website (www.auscr.com.au) for further information.

ACCESSING THE AUSCR

HOSPITAL ROLES AND GAINING ACCESS

There are two types of user accounts for hospital staff: Hospital Coordinator and Data Collector. Each site must have at least one designated Hospital Coordinator. Access to specific functions for the two roles are outlined in the table below.

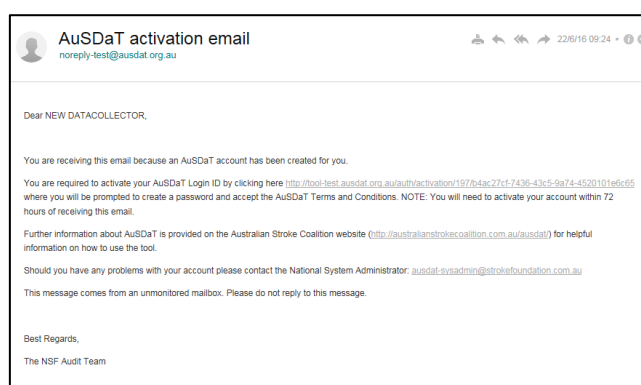
Function	Hospital Coordinator	Data collector
Dashboard and viewing notifications	✓	✓
User management <ul style="list-style-type: none"> • Create new Hospital Coordinator • Create new Data Collector 	✗ ✓	✗ ✗
Patient record management – <ul style="list-style-type: none"> • Search/view/create new/edit • Record a patient as deceased • Opt out a patient's personal information • Select patient follow-up refusal 	✓ ✓ ✓ ✓	✓ ✓ ✗ ✓
Patient record import – <ul style="list-style-type: none"> • View past imports • Import patient records • Export patient records 	✓ ✓ ✓	✓ ✗ ✗
Follow up record management	✓	✗
Reporting – <ul style="list-style-type: none"> • Generate Patient record reports • Generate Follow up reports 	✓ ✓	✓ ✓

A Hospital Coordinator can create Data Collector user accounts for hospital staff who will be entering data. See below under [Administration – Users](#) for instructions.

If a hospital needs a new Hospital Coordinator account to be created, please contact the AuSCR team at admin@auscr.com.au.

User accounts must only be used by the individual to whom they were assigned.

A new user will receive an automated email to activate their account (example below). They must do so by clicking on the link in the email within 72 hours, and entering in their password; see below under [Password and login](#) for more details.



Once you have activated your account, you can bookmark the login page in your browser, or get access to the login screen by clicking on the Registry Login link on the [AuSCR webpage](#).



If the account is not activated within the 72 hour timeframe, or if it is some time since you have used the AuSDaT and have forgotten your password, click on the Registry Login link as above, and then click on “Forgot your password?” on the login screen to set up or reset a password. A new email will be generated for you to create a password. If you do not receive this email, check your Junk Email folder.

The image shows the login screen for the Australian Stroke Data Tool (AuSDaT). At the top left is the AuSDaT logo. The main content area is titled "Please sign in" and contains two input fields: "Email" and "Password". Below these fields is a link that says "Forgot your password?" which is highlighted with a red rectangular box. At the bottom of the form is a blue button labeled "Sign in".

If you have any queries, or difficulties logging in or using the AuSDaT, contact your AuSCR state coordinator.

If you attempt to log in and your email or password are incorrect OR your account has expired, you will see this message:

Email or password are incorrect X

Please sign in

Email

Password

[Forgot your password?](#)

Note: for security purposes, the system displays the same message regardless of whether your email address or password are incorrect OR your account has expired.

Check your emails before clicking on “Forgot your password?”, as an email notification will be sent to you if your account has expired.

From: noreply@ausdat.org.au <noreply@ausdat.org.au>
Sent: Tuesday, 28 April 2020 3:37 PM
To: Jane Smith <janesmith@health.com>
Subject: AuSDaT expired account

Dear JANE SMITH,

You are receiving this email because you have attempted to login to an Australian Stroke Data Tool (AuSDaT) account that has expired. To re-activate your account, please contact ausdat@florey.edu.au.

This message comes from an unmonitored mailbox. Please do not reply to this message.

Best Regards,
 The AuSDaT Systems Administrator

Contact the AuSDaT Systems Administrator at ausdat@florey.edu.au to re-activate your account.

WEB BROWSER COMPATIBILITY

The AuSDaT has been built to work on all commonly used web browsers – Google Chrome, Firefox, Safari, and Internet Explorer (IE; backward compatible to IE8). It is not recommended that you run the tool on the early Internet Explorer versions (IE6 and IE7) because Microsoft no longer supports these web browsers. If you have an old version of Internet Explorer on your computer, please contact your IT department to update your version of Windows, or to install Chrome or another appropriate browser for you to use.

The AuSDaT can also be used on smart mobile devices, including Apple, Windows and Android phones and tablets, although screens may be more difficult to navigate.

PASSWORD AND LOGIN

When you first sign in, you will be prompted to set up your password and set up multi-factor authentication (MFA). For instructions on how to set up your MFA, see the [AuSDaT Multi-Factor Authentication User Guide](#) on the AuSCR website.

You will notice that the password strength meter changes colour (red to amber to yellow to green) as you enter your password. To meet the required strength level, your password will need:

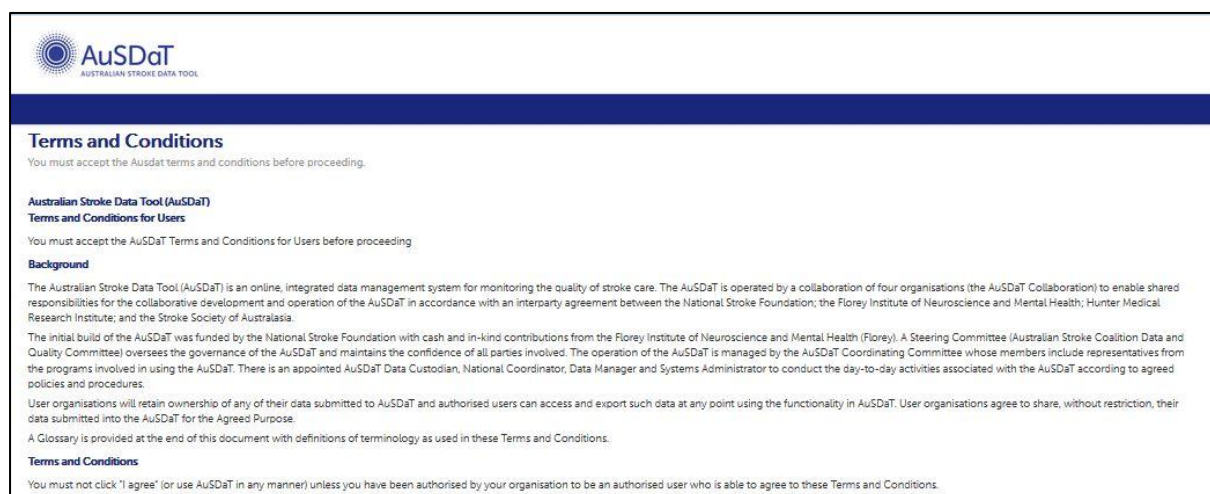
- A minimum of 8 characters;
- Both upper and lower case letters;
- Digits; and
- Non-alphabetical characters.

Once the appropriate strength of the password has been reached, the meter will become green. When you've successfully entered a new password click the "change" button, and do not disclose your password to anyone.

After you have confirmed your password, and each time you login to the AuSDaT, you will need to enter the authenticator code from your app to access the AuSDaT.

TERMS AND CONDITIONS AND STROKE FOUNDATION (SF) ORGANISATIONAL SURVEY

When logging on for the first time, you will need to accept the Terms and Conditions of the user licence before you can proceed. See below for sample screens; full Terms and Conditions are given in [Appendix 1](#).




If the Terms and Conditions change, you will be prompted to view and accept the new version when you next log in. You can access the current Terms and Conditions at any time by clicking on the link in the footer of the AuSDaT web tool.

New hospitals also need to complete the Stroke Foundation Organisational Survey to set up the hospital profile.

Stroke Foundation Organisational Survey for ...My Hospital...

To prevent data loss your survey edits are being automatically saved.

- Hospital details**
- Presentation to hospital
- Imaging, TIA and Neurovascular service
- Organisation of workforce
- Team coordination and assessment
- Access to further services
- Communication with patient and carer
- Continuing education

Submit

Hospital details

How many beds are there in your hospital?

Does your hospital have a specialist stroke unit(s)? ☐ Yes ☐ No

How many beds are in the stroke unit?

How many patients with acute stroke are present in the hospital today?

How many patients with acute stroke were admitted to your hospital in the previous calendar year (approx)?

How many of the stroke patients were specifically coded as **ischaemic strokes**? (include ICD-10 codes 163.0 - 163.9)

How many patients with acute stroke are present in the stroke unit today?

How many patients with acute stroke were admitted to the stroke unit in the previous calendar year?

Does your hospital have:


a. High Dependency/Intensive Care Unit? ☐ Yes ☐ No

b. Access to onsite neurosurgery? ☐ Yes ☐ No

Once this is completed, the screen will not appear in future logins.

Please ensure that the number of beds in your hospital is accurate, as this is used in Hospital Reports to compare similar sized hospitals.

Every year, during the Stroke Foundation audit, you will be asked to review the relevant organisational survey.



AuSDaT
AUSTRALIAN STROKE DATA TOOL

Stroke Foundation Organisational Survey for ...My Hospital

Please complete the Stroke Foundation Organisational Survey relevant to your position. Once successfully completed, you will be able to begin collecting patient record data for the clinical audit.

Select relevant survey ☒ Acute (this survey is due for review) ☐ Rehab

Continue Cancel

The Stroke Foundation keeps the organisational survey activated until every hospital participating in that year's audit has completed it. Until that time, click on "Acute (this survey has been completed and no further action is required)" and you will be taken to the dashboard.

Stroke Foundation Organisational Survey for ...My Hospital

Please complete the Stroke Foundation Organisational Survey relevant to your position. Once successfully completed, you will be able to begin collecting patient record data for the clinical audit.

Select relevant survey ☒ **Acute (this survey has been completed and no further action is required)** ☐ Rehab

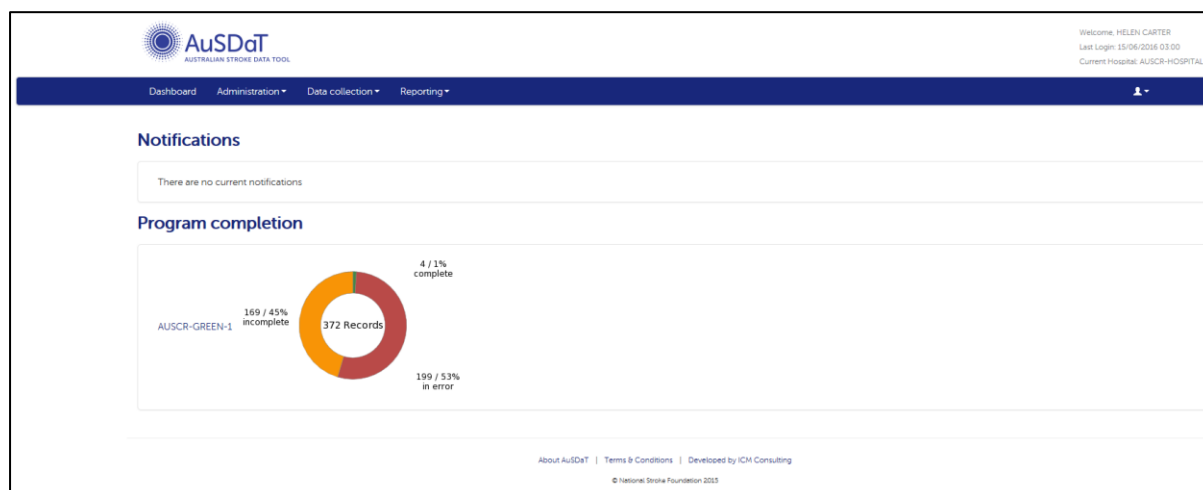
Continue Cancel

NAVIGATION MENU

DASHBOARD

Whenever you sign in, the first screen you see will be your home page or Dashboard. Here you can read the latest notifications issued by the AuSCR or AuSDaT team, and get a quick snapshot of your data collection status.

Once you have logged in, select “Dashboard” from the navigation menu to return to this page.

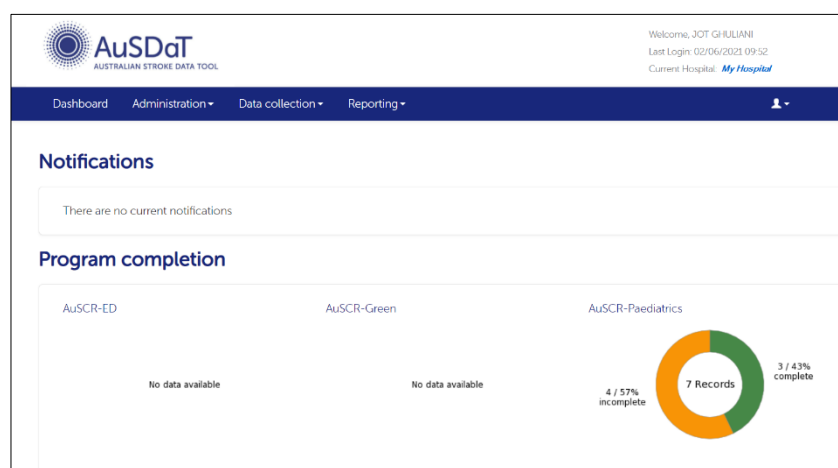


Each hospital will participate in one or more of a number of AuSCR programs, each containing a different combination of data variables. The program(s) in which you participate will be visible on the Dashboard, represented by circles (or “doughnuts”). Up to a maximum of three doughnuts will be displayed.

Further information on your AuSCR program, including all data elements collected, can be reviewed by clicking on the program name or the doughnut, which depicts the level of completeness of records within the program for the current year.

Note

- If your hospital participates in four or more programs, you will not be able to select which three program doughnuts are displayed as these determined by alphabetical order.
- A doughnut will not be displayed:
 - If there are no records in a program for that calendar year
 - For the AuSCR ED program as this program does not include the variable used to generate the doughnuts.



ADMINISTRATION

Under the Administration tab, there are three screens available to users; the most commonly used screen is the Users screen (see below for details.) The other screens, Hospital and Programs, show your hospital's details, and the details of the AuSCR program with which your hospital is registered.

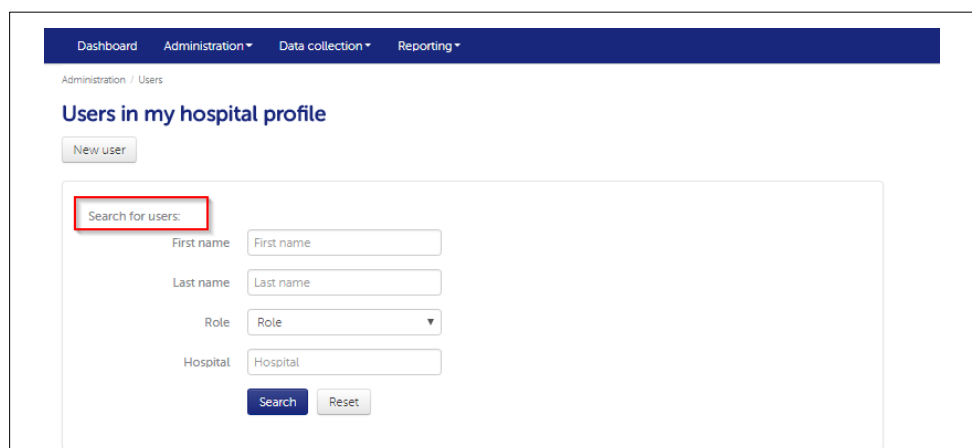
USERS

The Users screen lists all hospital staff that hold an AuSCR user account. If you are logged in as a Hospital Coordinator, you will be able to create a user account for one or more Data Collectors from this screen.

A Hospital Coordinator can only add Data Collectors working at your site. If you need to add another Hospital Coordinator, please contact the AuSCR team at admin@auscr.com.au. Data Collectors do not have access privileges to add other hospital users.

As a security feature, an email address can only be associated with one user account in the AuSDaT. In the rare occasion that a staff member requires two or more accounts, they will be required to use an alternate email address for email delivery of their activation link.

Before you add a new user, check the list of current users to make sure the person does not already have an existing account.



Dashboard Administration Data collection Reporting

Administration / Users

Users in my hospital profile

New user

Search for users:

First name First name

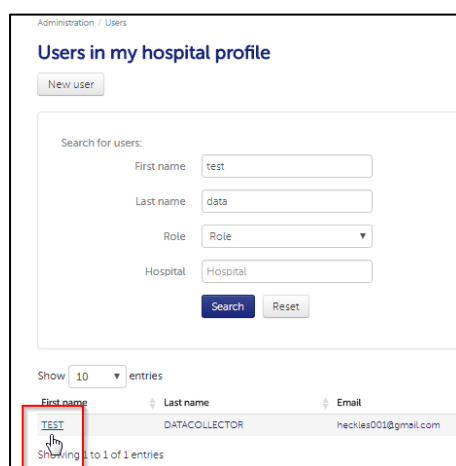
Last name Last name

Role Role

Hospital Hospital

Search Reset

If they are already in the system as a Data Collector and their email address has changed, a Hospital Coordinator can edit their current account rather than create a new account. Select their account, then click on "edit". If you do not have the required access, contact the AuSCR Office to make the change.



Administration / Users

Users in my hospital profile

New user

Search for users:

First name test

Last name data

Role Role

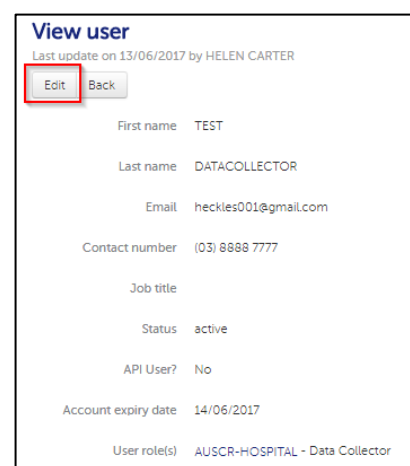
Hospital Hospital

Search Reset

Show 10 entries

First name	Last name	Email
TEST	DATACOLLECTOR	heckles001@gmail.com

Showing 1 to 1 of 1 entries



View user

Last update on 13/06/2017 by HELEN CARTER

Edit Back

First name TEST

Last name DATACOLLECTOR

Email heckles001@gmail.com

Contact number (03) 8888 7777

Job title

Status active

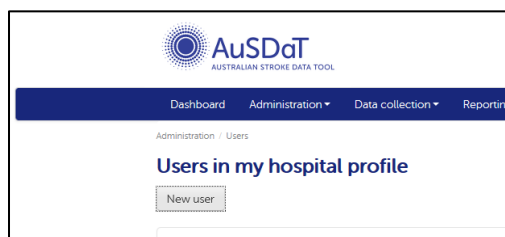
API User? No

Account expiry date 14/06/2017

User role(s) AUSTRALIAN HOSPITAL - Data Collector

The user can then click the "Forgot your password?" link on the login screen to set up a password on their new email address.

To add a new AuSCR user, click the “New user” button and complete the user profile details.



Note: the account expiry date for the user should be **2 years** from the current date for all hospital users, or less for casuals or staff temporarily seconded to their position, ensuring that the expiry date does not fall on a weekend or public holiday.

If a user account expires and the user requires continuing access, please email ausdat@florey.edu.au to have the account reactivated.

Once all required details have been entered, click on “Create” to finalise this process.

Where possible, enter and keep updated all fields of information as this helps inform the AuSCR staff of user contact details.

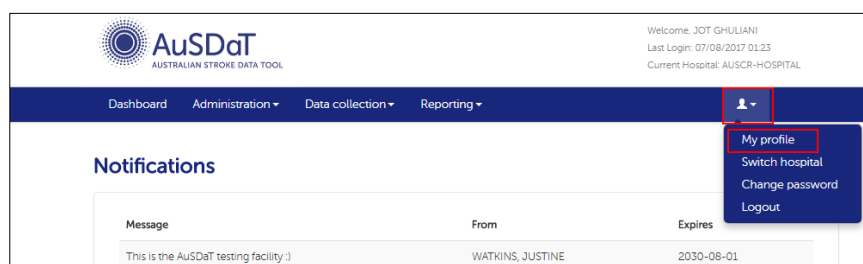
A screenshot of the 'New user' form in the AuSDaT application. The form is titled 'New user' and 'Add new user accounts for AuSDaT'. It contains several input fields: First name (Test), Last name (User), Email (tuser@hospital.com), Contact number ((03) 1234 5678), Job title (Stroke Unit Nurse), Account expiry date (10/08/2023), User role(s) (Hospital Coordinator / Data C), and Hospital & role (Training Hospital). There is a 'Data Collector' dropdown menu. At the bottom, there is a 'Create' button highlighted with a red box and a 'Cancel' button.

When a new user is added, an email inviting the user to activate their account will be generated automatically and sent to the user’s registered email address. See [Accessing AuSCR](#) for further details.

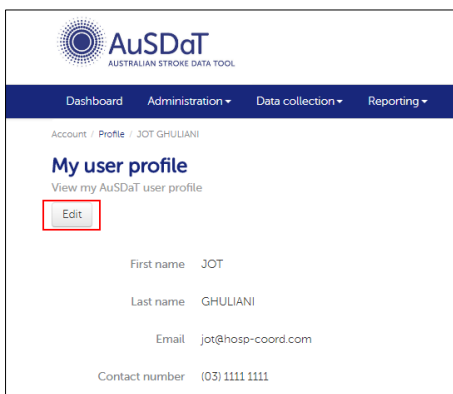
Editing your profile

All hospital users will be able to edit their personal details at any time once they have activated their accounts.

Click on the drop down arrow on the right hand side of the screen, and from the drop down list, select “My profile”.



Then click on “Edit”.



AuSDaT
AUSTRALIAN STROKE DATA TOOL

Dashboard Administration Data collection Reporting

Account / Profile / JOT GHULIANI

My user profile

View my AuSDaT user profile

Edit

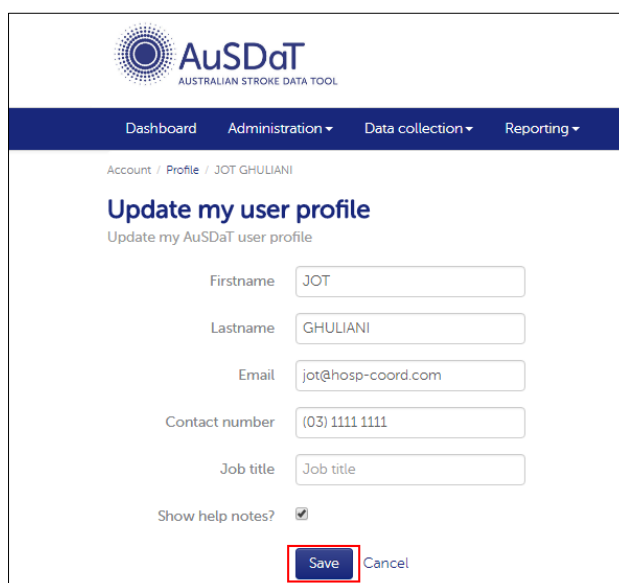
First name JOT

Last name GHULIANI

Email jot@hosp-coord.com

Contact number (03) 1111 1111

From this screen you can edit your profile, and switch the help notes on or off. After editing your details as appropriate, click on “Save”.



AuSDaT
AUSTRALIAN STROKE DATA TOOL

Dashboard Administration Data collection Reporting

Account / Profile / JOT GHULIANI

Update my user profile

Update my AuSDaT user profile

Firstname JOT

Lastname GHULIANI

Email jot@hosp-coord.com

Contact number (03) 1111 1111

Job title Job title

Show help notes? ☒

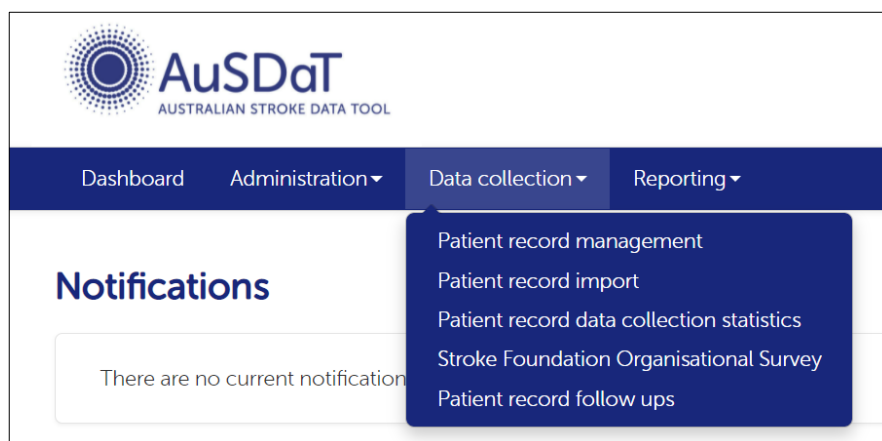
Save Cancel

If you need assistance with any of these processes, please contact the AuSCR office at admin@auscr.com.au.

DATA COLLECTION

You will be able to manage all your patient record data collection activities from this menu:

- Patient record management – create new records (see [below](#)) or view/edit existing records (see [below](#))
- Patient record import (see [below](#))
- Patient record data collection statistics (Hospital Coordinator only)
- Stroke Foundation Organisational Survey (see [above](#))
- Patient record follow ups (Hospital Coordinator only; see [below](#))




PATIENT RECORD MANAGEMENT

SEARCH FOR RECORDS

From the Data collection – Patient record management screen, you can search for a record by the system generated patient record ID number, or by any combination of first name, last name and date of birth. If your hospital participates in more than one AuSDaT program, you can choose whether to search in all programs, or a single program.

To search by MRN/UR number, click on “Show advanced search options”, enter the MRN and click Search. Other advanced options include searching for a range of admission or record creation dates.

SEARCHING FOR MULTIPLE PATIENTS

If you are searching for multiple records (e.g. a range of admission dates), you can open each patient record in a new browser tab by clicking on the button to the left of the AuSCR ID number: 

This will open the patient record in a new window, allow you to edit a record, and then return to your original search in the first window. You can also open multiple patient records for review at the same time.

Note: Your original search screen will time out after a set time period if the system does not register any activity on that screen. You will then have to run your search again.

CREATING A NEW PATIENT RECORD

Prior to creating a new patient record, you should use the search function (see below under [Editing information](#)) to ensure they are not already registered in the AuSCR.

To create a new patient record, select “New record” on the Patient Record Management Screen.



This takes you directly to the first data entry screen.

Data collection / Patient record management / New patient record

New patient record

Enter preliminary data for the new patient record

In order to create the new patient record, the following fields are required to be completed so a patient reference number can be generated.
Please fill in all the fields below, and click the "Create new record" button

First name

Last name

Date of birth

Gender

Admission date (optional)

Program(s) ☐ AUSCR-RED-1
☐ AuSCR FeSS V4
☐ AuSCR ED (Final)

Select the relevant program from your hospital's program(s) list.

Note:

- A FeSS record should only be expanded from an existing AuSCR record. See [Creating a FeSS record](#).
- An ED record should only be created if the patient was seen in your ED and then transferred to another hospital for further acute care. If the patient was admitted, they should only have an AuSCR record (and expanded to FeSS if relevant). See [Emergency Department \(ED\) module](#).
- You must enter the patient's first name, last name, date of birth and gender. These fields are used to create the patient's SLK (statistical linkage key), a unique reference code enabling linkage of data referring to the same patient without identifying the patient. If you don't enter all required fields, any missing items will be highlighted in red.
- If you are creating a record for an admitted episode e.g. AuSCR Red, enter the admission date. For AuSCR- ED records, leave the admission date field blank.

New patient record

Enter preliminary data for the new patient record

In order to create the new patient record, the following fields are required to be completed so a patient reference number can be generated.
Please fill in all the fields below, and click the "Create new record" button

First name This field is required.

Last name This field is required.

Date of birth This field is required.

Gender This field is required.

Admission date (optional)

After clicking the "Create new record" button, you are taken directly to the new Patient record edit form, allowing you to begin manually entering data. Click on each section heading to enter the data for that section. When you enter valid responses to all questions within a section, the section tab will turn green. If there are

any questions still awaiting a response, the section tab will continue to show as amber. The system auto-saves as data are entered.

Help notes are available for each variable and provide guidance on appropriate data entry responses. These become visible when you click in the field.

The screenshot shows a 'Patient demographics' form. Fields include First name (ICM), Last name (NEW), Date of birth (01/03/1970), Age, Gender (dropdown menu), Interpreter needed (dropdown menu), and Is the patient of Aboriginal/Torres Strait Islander origin? (checkbox). A red box highlights the Gender dropdown menu, which is open, showing options: Male, Please select, Male, Female, Intersex or indeterminate, and Not stated/inadequately described. A help note for Gender is displayed, stating: 'Operationally, gender will be captured as it is written in the medical record. If there is a conflict, document with the self identified gender, i.e. gender as reported by the person.'

Once you become familiar with the questions and the data entry process, you have the option to turn the help notes off via your user profile settings; see the [Editing your profile](#) section for details.

If you enter an incorrect response to a question, an error message will appear in red text, and the section tab will appear in red. You will know that your answers are valid when no error messages appear as you enter details.

The screenshot shows the 'AuSDaT AUSTRALIAN STROKE DATA TOOL' interface. The 'Patient record edit' page is displayed, showing record attributes (Patient record ID: 193676, Name: Jane DOE, Admission date: 01/08/2019) and a 'Collect data' section. The 'Patient demographics' section is active, showing fields for Title, First name, Last name, Date of birth, Medicare number, and Hospital Medical Record Number (MRN). The 'Date of birth' field contains '01/04/19456' and is highlighted with a red box. A red error message is displayed next to it: 'You must enter a date in format 'dd/mm/yyyy''. The left sidebar shows a list of data collection categories, with 'Patient demographics' highlighted in red.

If questions have been disabled based on a valid response to a previous question, the questions will grey out and you will not be able to enter data for these questions. The question will be shown as complete (green) in the patient record view.

Admission details

Onset date03/03/2016Unknown

Date accuracy

Accurate

Estimate

Onset time

Time accuracy

Please select

Did the stroke occur while the patient was in hospital?

Yes

No

Unknown

Date of arrival to emergency department

Date accuracy

Accurate

Estimate

Time of arrival to emergency department

Unknown

Time accuracy

Accurate

Estimate

Did the patient arrive by ambulance?

Yes

No

Unknown

Admission details

Onset date03/03/2016Unknown

Date accuracy

Accurate

Estimate

Onset time

Time accuracy

Please select

Did the stroke occur while the patient was in hospital?

Yes

No

Unknown

Date of arrival to emergency department

Date accuracy

Accurate

Estimate

Time of arrival to emergency department

Unknown

Time accuracy

Accurate

Estimate

Did the patient arrive by ambulance?

Yes

No

Unknown

The patient record entry form includes many instances of programmed logic, i.e. data validations to help you collect accurate patient data. For example, certain dates that you enter must be on or after a previously entered date, minimising the risk of incorrect dates being recorded.

Admission details

Onset date03/03/2016Unknown

Date accuracy

Accurate

Estimate

Onset time

Time accuracy

Please select

Did the stroke occur while the patient was in hospital?

Yes

No

Unknown

Date of arrival to emergency department03/03/2016

Date accuracy

Accurate

Estimate

Time of arrival to emergency department

Unknown

Time accuracy

Accurate

Estimate

Did the patient arrive by ambulance?

Yes

No

Unknown

Was the patient transferred from another hospital?

Yes

No

Unknown

Date of admission to hospital03/02/2016

Date of admission must be on or after date of arrival.

NOTES ON SPECIFIC SECTIONS AND FIELDS

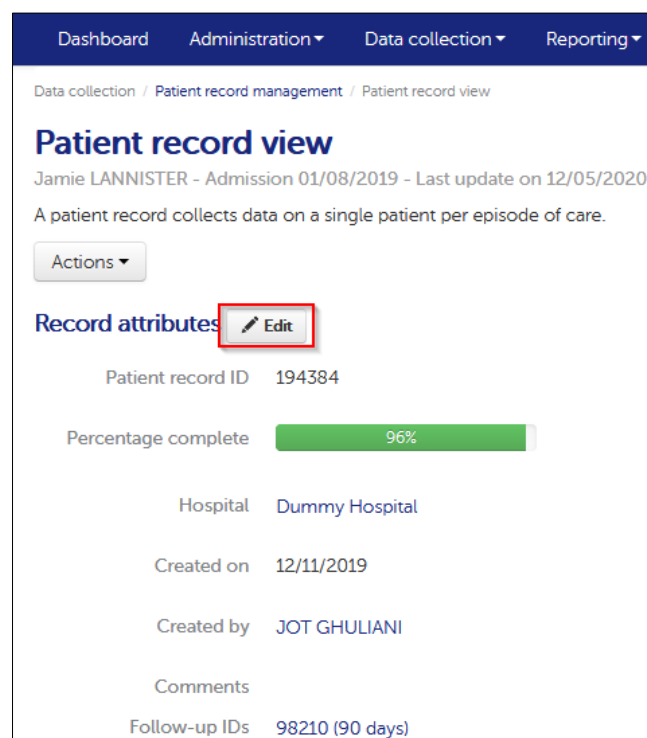
Date fields

Instead of using the mouse to complete date fields, type in the date you need in the right format (DD/MM/YYYY). This will be much quicker.

Comments field

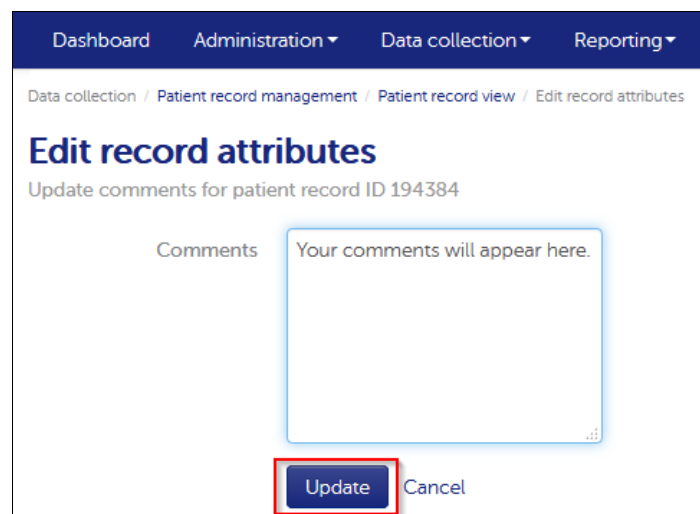
Every patient record created in the AuSDaT has a free text box to record additional explanatory notes about an episode of care.

In the Patient record view screen, click on Edit.



The screenshot shows the 'Patient record view' screen. At the top, there is a navigation bar with 'Dashboard', 'Administration', 'Data collection', and 'Reporting'. Below this, the breadcrumb trail reads 'Data collection / Patient record management / Patient record view'. The main heading is 'Patient record view'. Below the heading, it says 'Jamie LANNISTER - Admission 01/08/2019 - Last update on 12/05/2020'. A description states 'A patient record collects data on a single patient per episode of care.' There is an 'Actions' dropdown button. Under 'Record attributes', there is an 'Edit' button with a pencil icon, which is highlighted with a red box. Below this, the following attributes are listed: 'Patient record ID' 194384, 'Percentage complete' 96% (with a green progress bar), 'Hospital' Dummy Hospital, 'Created on' 12/11/2019, 'Created by' JOT GHULIANI, 'Comments' (with a text box), and 'Follow-up IDs' 98210 (90 days).

Enter your comments in the free text box, then click on Update. The text box has an unlimited character length; we suggest adding paragraph breaks to long comments to avoid text running off the screen.



The screenshot shows the 'Edit record attributes' screen. At the top, there is a navigation bar with 'Dashboard', 'Administration', 'Data collection', and 'Reporting'. Below this, the breadcrumb trail reads 'Data collection / Patient record management / Patient record view / Edit record attributes'. The main heading is 'Edit record attributes'. Below the heading, it says 'Update comments for patient record ID 194384'. There is a 'Comments' label next to a large text box containing the placeholder text 'Your comments will appear here.'. Below the text box, there are two buttons: 'Update' and 'Cancel'. The 'Update' button is highlighted with a red box.

You will be taken back to the Patient record view screen, where your comments will now be visible.

Dashboard
Administration
Data collection
Reporting

Data collection / Patient record management / Patient record view

Patient record view

Jamie LANNISTER - Admission 01/08/2019 - Last update on 12/05/2020

A patient record collects data on a single patient per episode of care.

Actions

Record attributes Edit

Patient record ID 194384

Percentage complete

96%

Hospital Dummy Hospital

Created on 12/11/2019

Created by JOT GHULIANI

Comments Your comments will appear here.

Follow-up IDs 98210 (90 days)

Note: these comments are for hospital reference only. While AuSCR staff are able to view these comments, generally they will not be reviewed or used in analysis.

Stroke onset date and time

Stroke onset can be recorded as a known time of onset, uncertain time of onset, wake-up stroke, or time unknown. Where there is an uncertain time of onset, or patient woke with symptoms, record the time they were last seen well, e.g. the time they went to sleep.

There are different options for entering the stroke onset date:

1. Stroke onset date is known: enter date and select "Accurate".

Admission details

Onset date ☐ Unknown

Date accuracy ☒ Accurate ☐ Estimate

Onset time

Time accuracy

2. Approximate stroke onset date known: enter date and select "Estimate".

Admission details

Onset date ☐ Unknown

Date accuracy ☐ Accurate ☒ Estimate

Onset time

Time accuracy

3. Only the month and year are known: enter 01/MM/YYYY and select “Estimate”.

Admission details

Onset date 01/02/2016 ☐ Unknown

Date accuracy ☐ Accurate ☒ Estimate

Onset time

Time accuracy Please select

4. Onset date not known: select “Unknown” and the other onset date and time fields will be greyed out.

Admission details

Onset date ☒ Unknown

Date accuracy ☐ Accurate ☐ Estimate

Onset time

Time accuracy Please select

Admission and transfer information – “Not admitted” field

The AuSCR admitted datasets (Red, Black, Navy, Violet, and Paediatrics) do not collect data on patients not admitted to hospital for care. AuSDaT bundles admission data together such that the admission details screen includes the variable “Not admitted”. This field is not applicable for the AuSCR admitted datasets. When completing admission details, this field should be left blank. For those hospitals submitting their data within the AuSCR import template, this field needs to be coded as “false”.

Was the patient transferred from another hospital? ☐ Yes ☒ No ☐ Unknown

Date of admission to hospital 01/06/2016

☐ Not admitted

Date accuracy ☒ Accurate ☐ Estimate

Time of admission to hospital 21:43 ☐ Unknown

Time accuracy ☒ Accurate ☐ Estimate

The AuSCR Emergency Department (ED) dataset collects data on patients treated in the emergency department and then transferred to another hospital for further acute management.

The “Not admitted” variable is not included in the AuSCR ED dataset.

Discharge information, including in-hospital death

If a patient has died during the acute episode of care, select Yes for “Patient deceased during hospital care”, then enter the date of death and the accuracy of death date.

This will grey out some other fields in this section, but you will still need to enter the principal diagnosis for the episode of care, plus any additional diagnosis, complication and procedure codes.

Auditor information

Patient demographics

Admission and transfer information

Pre stroke history

Acute clinical data

Telemedicine and reperfusion

Other clinical information

Secondary prevention

Discharge information

Return to view

Discharge information

Patient deceased during hospital care? ☒ Yes ☐ No

Date of death

Accuracy ☒ Accurate ☐ Estimate

Is the date of discharge known? ☐ Yes ☐ No

Date of discharge

Accuracy ☐ Accurate ☐ Estimate

What is the discharge diagnosis ICD 10 Classification Code?

Other (specify)

What is the Medical Condition ICD 10 Classification Code?

What is the Medical Complication ICD 10 Classification Code?

What is the Medical Procedure ICD 10 Classification Code?

What is the discharge destination/mode?

Please specify (if discharged/transferred to residential aged care service) ☐ Low level residential care ☐ High level residential care

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)?

For a post discharge death, see instructions below under [Record a patient as deceased](#).

Recording of ICD-10 classification codes

Each episode of care requires a single principal ICD-10 diagnosis code, plus additional diagnosis and procedure codes where applicable, to be entered in to the record. These codes are as assigned by the Health Information staff of the hospital, and should not be coded by those responsible for AuSCR data collection/entry.

If entering ICD-10 codes in the AuSCR, select the principal code from the dropdown list. If the principal diagnosis code is not one of the Stroke/TIA codes on the list, select “Other”, and type in the principal diagnosis code in the “Other (specify)” field.

What is the discharge diagnosis ICD 10 Classification Code?

Other

Other (specify)

I25.11

When recording multiple additional diagnosis or procedure codes (Medical Condition, Medical Complication, or Medical Procedure fields), separate each code with a comma. If there are no additional codes to enter, leave the field blank.

What is the discharge diagnosis ICD 10 Classification Code?	I63.8
Other (specify)	
What is the Medical Condition ICD 10 Classification Code?	G30.9,F00.9,Z86.43
What is the Medical Complication ICD 10 Classification Code?	
What is the Medical Procedure ICD 10 Classification Code?	95550-02,95550-03
What is the discharge destination/mode?	Usual residence (e.g. home) w

Recording acute occlusion sites

This section is only applicable to the AuSCR Black and Violet programs, and is only relevant where patients have undergone endovascular clot retrieval. If the acute occlusion site(s) is/are known, all ischaemic areas should be recorded. Ensure that the side of the brain affected is recorded, along with the specific site(s) as appropriate.

Acute occlusion sites	
Left	<input checked="" type="checkbox"/>
Right	<input type="checkbox"/>
ICA-EC	<input type="checkbox"/>
ICA-IC	<input checked="" type="checkbox"/>
MCA-M1	<input checked="" type="checkbox"/>
MCA-M2	<input type="checkbox"/>
MCA-M3	<input type="checkbox"/>
ACA	<input type="checkbox"/>
PCA	<input type="checkbox"/>
BA	<input type="checkbox"/>
VA	<input type="checkbox"/>
No occlusion	<input type="checkbox"/>
Not documented	<input type="checkbox"/>
Other	<input type="checkbox"/>

EDITING INFORMATION (EXISTING PATIENTS)

When you select a patient record for editing, you will be taken to the patient record view. This gives an overview of the record's completeness, as well as showing the completeness of each section, and the location of any errors. You then need to click the "Edit" button to enter data entry mode.

Patient record view

Jon Snow - Admission 15/05/2018 - Last update on 11/02/2019 by HELEN CARTER

A patient record collects data on a single patient per episode of care.

Actions ▾

Record attributes

Patient record ID 191255

Percentage complete

83%

Hospital Dummy Hospital

Created on 09/10/2018

Created by SAM DATA ADMIN

Programs

This record includes data collected for the following programs:

Program	Completeness	Errors	Incomplete	Complete	Status	Action
AUSCR-RED-1	<div><div>4%</div><div>14%</div></div>			<div>82%</div>	open	No actions available

Expand this record for: Select programs ▾

Collected data

Auditor information

Patient demographics

Admission and transfer information

Pre stroke history

Acute clinical data

Admission and transfer information

Edit

Admission details

Ref	Name	Value	Status
4.00	Onset date	No value entered	<div>✗</div>
4.01	Unknown	No	<div>✓</div>

Collecting for [AUSCR-RED-1](#)

REVIEWING RECORDS FOR COMPLETENESS

If you want to review records with incomplete data or error flags, you can search under advanced search options. Note that this option is only enabled when you select a specific program to search. Select “Errors” for any records that contain data entry errors, or “Incomplete” for records with no errors but have data missing in one or more fields.

Patient record management

New record

All AUSCR-RED-1 AuSCR FeSS (Final)

Go to patient record

ID Go

Search for patient records:

First name

Last name

Gender

Date Of Birth

Admission date From To

Date created From To

MRN

State

Opt-out

Opt-out date From To

Error/Completion State

Complete
Incomplete
Errors

EXPANDING RECORDS

If your hospital participates in more than one program that uses the AuSDaT to collect data, a patient may be registered in more than one of these programs. Rather than duplicating data entry for variables that are common to these programs (e.g. demographic data), the AuSDaT allows for expansion of records, where these common variables are already completed by the first program which created the record.

Note, an ED episode should not be expanded to an admitted episode, and an admitted episode should not be expanded to an ED episode.

A record should only be expanded if the patient's name, date of birth, sex, AND date of admission are identical. Search for your patient and check the "Admission date" field.

The screenshot shows the 'Patient record management' interface. At the top, there are tabs for 'Dashboard', 'Administration', 'Data collection', and 'Reporting'. Below these, the 'Data collection / Patient record management' section is active. A 'New record' button is present. A navigation bar shows various program filters: 'All', 'AUSCR-BLACK-1', 'AUSCR-BLUE-1', 'AUSCR-GREEN-1', 'AUSCR-MAROON-1', 'AUSCR-PURPLE-1', and 'AUSCR-RED-1'. The main search area has a 'Go to patient record' section with an 'ID' field and a 'Go' button. Below this is a 'Search for patient records' section with fields for 'First name' (containing 'jo may'), 'Last name' (containing 'bro'), 'Gender' (a dropdown menu), and 'Date Of Birth' (a date field). There is a 'Show advanced search options' link and 'Search' and 'Reset' buttons. At the bottom, a table displays search results. The table has columns: 'ID', 'First name', 'Last name', 'Gender', 'Date Of Birth', 'Admission date', and 'Date cre'. The first row shows '186586', 'Jo May', 'BRO', 'Male', '01/01/1945', '03/04/2017', and '03/04/2'. The 'Admission date' column is highlighted with a red box. Below the table, it says 'Showing 1 to 1 of 1 entries'.

ID	First name	Last name	Gender	Date Of Birth	Admission date	Date cre
186586	Jo May	BRO	Male	01/01/1945	03/04/2017	03/04/2

If this is the same episode as the new program data, then select the patient to take you to the "Patient record view" screen, where you can see the program(s) relevant to this patient episode.

If the date of admission is not the same, a new episode should be created. See the [New episode for an existing patient](#) section.

In the screenshot below, this patient is already participating in the BEEPRS program.

Patient record view
Jo May BRO - Admission 03/04/2017 - Last update on 02/05/2017 by SAM HOSPITAL COORD

A patient record collects data on a single patient per episode of care.

Record attributes

Patient record ID: 186586

Percentage complete: 98%

Hospital: AUSCR-HOSPITAL

Created on: 03/04/2017

Created by: JOT GHULIANI

Programs

This record includes data collected for the following programs:

Program	Completeness	Errors	Incomplete	Complete	Status	Action
BEEPRS	98%				open	No actions available

Expand this record for: [Select programs](#)

If you wish to add this patient to an AuSCR program, click on “Select programs”.

A list of all your hospital’s programs will become visible. Select the appropriate program and click “Expand”:

Patient record view
Jo May BRO - Admission 03/04/2017 - Last update on 02/05/2017 by SAM HOSPITAL COORD

A patient record collects data on a single patient per episode of care.

Record attributes

Patient record ID: 186586

Percentage complete: 98%

Hospital: AUSCR-HOSPITAL

Created on: 03/04/2017

Created by: JOT GHULIANI

Programs

This record includes data collected for the following programs:

Program	Completeness	Errors	Incomplete	Complete	Status	Action
BEEPRS	98%				open	No actions available

Expand this record for: [Select programs](#)

Collected data

- ☒ AUSCR-BLUE-1
- ☐ AUSCR-PURPLE-1
- ☐ AUSCR-MAROON-1
- ☒ **AUSCR-BLACK-1**
- ☐ AUSCR-GREEN-1
- ☐ GREEN-migrate
- ☐ AuSCR-RED-migrate
- ☐ BLACK-migrate
- ☐ AUSCR-RED-1

[Expand](#)

Auditor information [Edit](#)

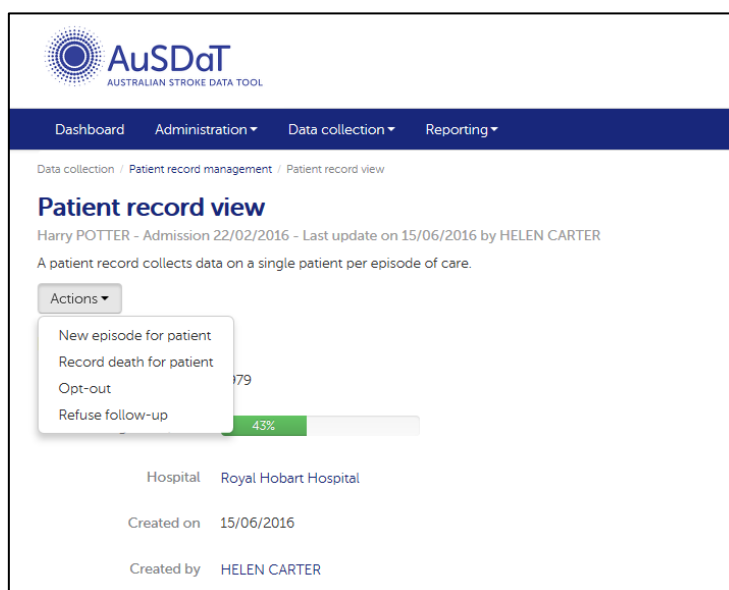
Ref	Name
1.00	Hospital name
1.02	Auditor name

This will then allow you to enter the data for the variables that are specific to the AuSCR program, and to edit any existing data if required.

IMPORTANT NOTE: Once a record is expanded, a Hospital user CANNOT reverse the expansion – it needs to be done by an AuSCR Data Manager, so ensure that this is the correct action to take.

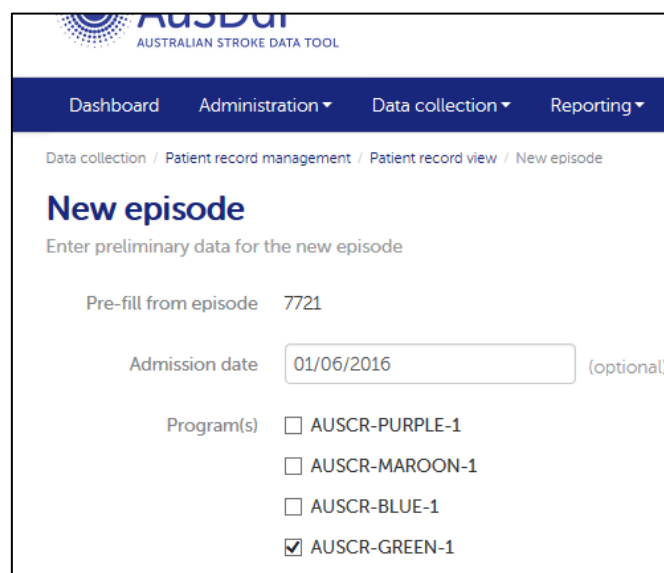
ACTIONS

When a patient record has been selected, the Patient record view allows further actions to be taken using the “Actions” drop down list. The actions are: New episode, Record death, Opt-out (for Hospital Coordinator level access only) and Refuse follow-up.



New episode for an existing patient

To add a new episode to an existing patient record, select Actions, “New episode for patient”, and enter in the new admission date. Any Patient demographics fields will be transferred to the new episode record automatically, and can be edited if required. All other sections will need to be added specifically for the new episode. Patient and alternate contact details need to be updated for follow-up, as appropriate.



Record a patient as deceased

If a patient has died during their acute episode of care, follow the instructions above under [Discharge information, including in-hospital death](#).

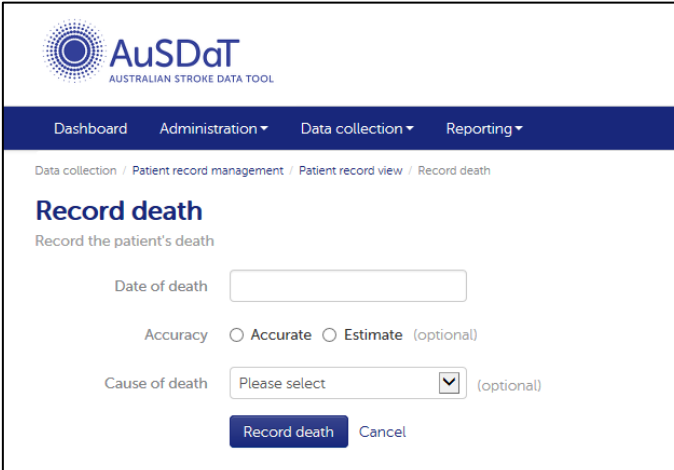
If a hospital is notified that a patient has died subsequent to their acute episode of care, this should be recorded on the AuSCR as soon as possible, to avoid unnecessary follow-up.

You can record a patient's death on an existing Patient Episode Record using the "Record patient death" option under Actions.



The screenshot shows the AuSDaT (Australian Stroke Data Tool) interface. The top navigation bar includes Dashboard, Administration, Data collection, and Reporting. The breadcrumb trail is Data collection / Patient record management / Patient record view. The main heading is "Patient record view" for patient "Scooby DOO", with admission on 01/08/2016 and last update on 24/08/2016 by KASEY WALLIS. A description states: "A patient record collects data on a single patient per episode of care." An "Actions" dropdown menu is open, showing options: "New episode for patient", "Record death for patient", "Opt-out", and "Refuse follow-up". Below the menu, a progress bar shows 54% completion. The hospital is listed as "AUSCR-HOSPITAL" and the record was created on "24/08/2016".

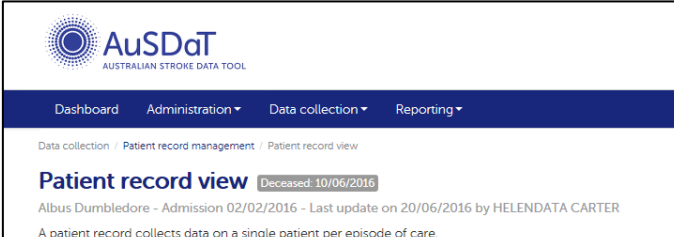
The date of death and cause (if known) can be selected on the Record death screen. In order to save this information, click the "Record death" button.



The screenshot shows the "Record death" form in the AuSDaT interface. The breadcrumb trail is Data collection / Patient record management / Patient record view / Record death. The heading is "Record death" with the instruction "Record the patient's death". The form includes a "Date of death" text input field, an "Accuracy" section with radio buttons for "Accurate" and "Estimate (optional)", and a "Cause of death" dropdown menu with "Please select" and a checkmark icon, labeled "(optional)". At the bottom are "Record death" and "Cancel" buttons.

Once a patient has been marked as deceased they will automatically be removed from the follow-up process. On some occasions, the follow-up process for the patient may have been generated and initiated before their death has been recorded. In these circumstances, the AuSCR office will ensure no further follow-up is undertaken once death notification has been received.

After the patient has been recorded as deceased after discharge, the Patient record view is marked with the date of death for future reference.



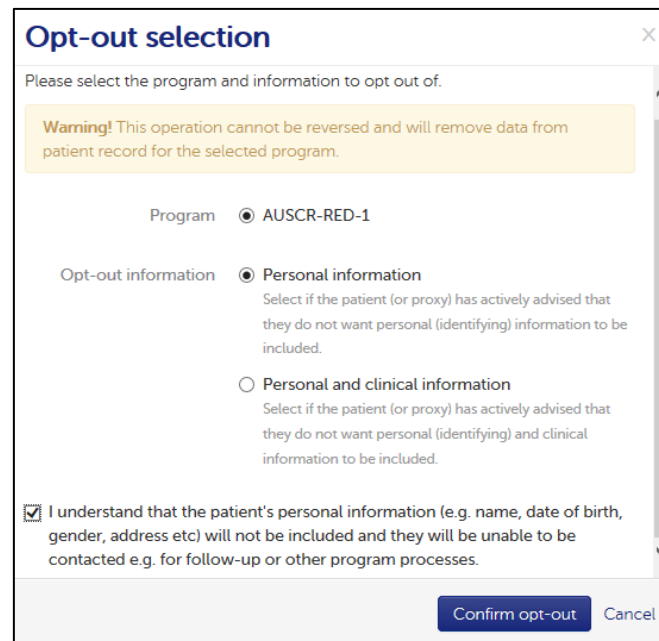
The screenshot shows the AuSDaT interface with the breadcrumb trail Data collection / Patient record management / Patient record view. The heading is "Patient record view" for patient "Albus Dumbledore", with admission on 02/02/2016 and last update on 20/06/2016 by HELENDATA CARTER. A status tag "Deceased: 10/06/2016" is displayed next to the heading. A description states: "A patient record collects data on a single patient per episode of care."

Opt-out

Your hospital has received ethics approval to retain anonymous clinical information, so that your hospital can evaluate and improve the stroke care it provides, but patients can opt out their personal information from the registry at any time.

Therefore, when you select “Opt-out” from the Actions drop-down list, you need to select “Personal information” only, as well as the relevant program, and then click on “Confirm opt-out”.

It is important that patients who opt out of AuSCR still have their episode(s) of care entered on the AuSDaT before being opted out. This ensures that case ascertainment and opt-out statistics remain accurate.



The image shows a web-based dialog box titled "Opt-out selection" with a close button (X) in the top right corner. Below the title, it says "Please select the program and information to opt out of." A yellow warning box contains the text: "Warning! This operation cannot be reversed and will remove data from patient record for the selected program." Below this, there are two sections. The first is "Program" with a radio button selected next to "AUSCR-RED-1". The second is "Opt-out information" with two radio button options: "Personal information" (selected) and "Personal and clinical information". Each option has a descriptive text below it. At the bottom, there is a checked checkbox with the text: "I understand that the patient's personal information (e.g. name, date of birth, gender, address etc) will not be included and they will be unable to be contacted e.g. for follow-up or other program processes." At the very bottom, there are two buttons: "Confirm opt-out" (in blue) and "Cancel" (in grey).

After a patient has been opted out, their personal information will no longer appear on screen, and you will not be able to search on any patient details, including the MRN. We recommend you record this action, so that you do not attempt to re-enter this patient at a later stage.

The option to remove both personal and clinical information is available, should patients explicitly request this.

Where patients are involved in multiple AuSCR programs, such as AuSCR-Red and AuSCR-FeSS, they will need to be opted out of both programs (i.e. complete this step twice), to ensure all personal details are removed.

Search for patient records:

First name

First name

Last name

Last name

Gender

Gender

▼

Date Of Birth

Date Of Birth

Hospital

auscr

▼ Show advanced search options

Search

Reset

Show 10 entries

Export

Bulk update

ID	First name	Last name	Gender	Date Of Birth	Admission date	Date created	Date updated	Program	Completeness	Hospital
7965	test	DEADRECORD	Male	07/06/1970	20/02/2016	08/06/2016	08/06/2016	AUSCR-GREEN-1	54%	AUSCR-HOSPITAL
7966	Test	Import	Male	01/01/1980	02/02/2016	10/06/2016	20/06/2016	AUSCR-GREEN-1	57%	AUSCR-HOSPITAL
149428	Tina	TURNER	Female	09/09/1950	01/07/2016	08/07/2016	08/07/2016	AUSCR-BLACK-1	53%	AUSCR-HOSPITAL
185130	Upper	Urban	Female	11/12/1934	16/03/2016	04/08/2016	04/08/2016	AUSCR-BLACK-1	79%	AUSCR-HOSPITAL
185133	Upper2	Underhill	Male	08/10/1957	20/04/2016	04/08/2016	04/08/2016	AUSCR-BLACK-1	77%	AUSCR-HOSPITAL
149429	Viktor	KRUM	Male	01/08/1940	01/07/2016	08/07/2016	14/07/2016	AUSCR-GREEN-1	57%	AUSCR-HOSPITAL
7767					02/03/2016	24/05/2016	12/06/2016	AUSCR-GREEN-1	100%	AUSCR-HOSPITAL
7598					04/03/2016	24/05/2016	07/06/2016	AUSCR-GREEN-1	88%	AUSCR-HOSPITAL
185190					01/04/2016	12/08/2016	15/08/2016	AUSCR-BLACK-1	68%	AUSCR-HOSPITAL

Refuse follow-up

If a patient does not wish to be followed up, select “Refuse follow-up” from the Actions drop down list.

Refuse follow-up selection

Please select the program this patient record is not to be contacted for follow-up.

Warning! This operation cannot be reversed and will permanently remove this patient record from the selected program's follow-up generation.

Program

☐ AUSCR-GREEN-1

Confirm refuse follow-up

Cancel

Select the relevant program, and click “Confirm refuse follow-up” to ensure that the patient will not receive the follow-up survey.

EMERGENCY DEPARTMENT (ED) MODULE

BACKGROUND INFORMATION

- This **optional** AuSCR module collects information on the provision of care for patients with stroke who are to be transferred from your Emergency Department (ED) to another hospital for ongoing acute care.
- Collection of data in the ED module will assist hospitals to gain a greater understanding of stroke care provided within their ED, including the ability to report the use of thrombolysis and the provision of other evidence-based care consistent with the clinical guidelines for stroke.
- The following episodes are eligible for inclusion:
 - Patients that attend your ED and are subsequently transferred for further acute stroke care at another hospital
 - All stroke types as well as TIAs.
- The ED module EXCLUDES:
 - Patients who die in the ED
 - Patients who are discharged to their usual residence
 - Patient who are admitted at your hospital (their data will be captured within your current AuSCR program).
- The variables captured in the ED module include patient demographics, onset and arrival details, reason(s) for transfer, pre-morbid mRS, NIHSS, brain scans, telemedicine, thrombolysis, and swallow variables.
- The advantages of using the ED module include:
 - Documentation of all thrombolysis provided at your hospital
 - Ability to track care provided in the ED prior to transfer (e.g. advanced imaging, swallow screen)
 - Ability to track time-related metrics such door-to-CT; door-to-needle and door-in door-out times
 - Comparisons of ED metrics at your hospital with peer, state and all AuSCR hospitals
 - ED data collected can be used to drive local quality improvement projects.
- When creating a new patient record, tick the 'ED dataset' box and then the process for creating an ED dataset record is the same as for creating a current AuSCR admitted episode.
- If your patient is seen in your ED, transferred to another hospital, and then returns back to your hospital for further acute care, you will create a new AuSCR record. Do not expand the original ED record.

FEVER, SUGAR, SWALLOWING (FESS) MODULE

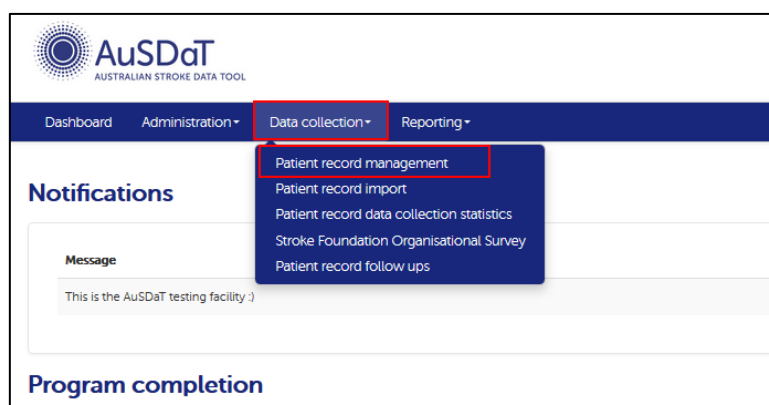
BACKGROUND INFORMATION

- Protocols for the management of fever, hyperglycaemia, and swallowing dysfunction have the potential to reduce long-term mortality and disability after discharge from stroke units. Evidence shows that these protocols are highly cost effective.
- The Stroke Foundation's 2017 Clinical Guidelines for Stroke Management have a strong recommendation for standardised protocols to manage fever, hyperglycaemia, and swallowing difficulties.
- The fever, sugar, swallowing (FeSS) Program on the AuSDaT enables monitoring for quality improvement in line with these recommendations.
- The swallow variables, included in the FeSS dataset, are already being collected as part of the AuSCR.
- Participation in the FeSS program, and collection of the additional fever and sugar variables, is voluntary, but opting in to this program allows clinicians to collect these data to monitor their continued progress in following the recommended protocols. Additionally, these are the only processes of stroke care for nursing which are backed up with high quality evidence, and as such, are of direct relevance to care provided by the largest workforce in stroke.

Note: Only patients who have already been added to the AuSCR should be included in the FeSS program, i.e. the AuSCR record needs to be created in the AuSDaT first.

CREATING A FESS RECORD

In the "Data collection" tab, select "Patient record management"



Search for the patient by entering first name, last name (and date of birth, if required).

Patient record management

New record

AllAUSCR-RED-1AuSCR FeSS (Final)

Go to patient record

IDIDGo

Search for patient records:

First nameMobile

Last namePhone

GenderGender

Date Of BirthDate Of Birth

Show advanced search options

SearchReset

Check that you have the correct date of admission, then click on the icon next to the patient ID number. This will open up the patient record in a new tab.

Patient record management

New record

AllAUSCR-RED-1AuSCR FeSS (Final)

Go to patient record

IDIDGo

Search for patient records:

First nameMobile

Last namePhone


GenderGender

Date Of BirthDate Of Birth

Show advanced search options

SearchReset

Show10entries

ID	First name	Last name	Gender	Date Of Birth	Admission date
 191177	Mobile	PHONE	Female	26/04/1948	01/09/2018

Showing 1 to 1 of 1 entries

Click on the “Select programs” drop down list and select the relevant program, “AuSCR FeSS (Final)” in this screenshot. Note that your hospital may be participating in a number of different programs e.g. AuSCR Red, Stroke Foundation audit, and AuSCR FeSS.

Click on “Expand”

Dashboard Administration Data collection Reporting

Data collection / Patient record management / Patient record view

Patient record view

Mobile PHONE - Admission 01/09/2018 - Last update on 09/10/2018 by SAM PROG COORD

A patient record collects data on a single patient per episode of care.

Actions

Record attributes

Patient record ID 191177

Percentage complete 99%

Hospital Apple Hospital

Created on 04/10/2018

Created by JOT GHULIANI

Programs

This record includes data collected for the following programs:

Program	Completeness	Errors	Incomplete	Complete	Status
AUSCR-RED-1	99%				open

Expand this record for:

Select programs

☒ AuSCR FeSS (Final)

Expand

Collected data

Click on “Edit”

Programs

This record includes data collected for the following programs:

Program	Completeness	Errors	Incomplete	Complete	Status	Action
AUSCR-RED-1	6% 94%				open	No actions available
AuSCR FeSS (Final)	13% 87%				open	No actions available

Collected data

- ☒ Auditor information
- ☐ Patient demographics
- ☐ Admission and transfer information
- ☐ Pre stroke history
- ☐ Acute clinical data
- ☐ Telemedicine and reperfusion
- ☐ Other clinical information
- ☐ Secondary prevention
- ☐ Discharge information

Auditor information Edit

Ref	Name	Value
1.00	Hospital name	Apple Hospital
1.02	Auditor name	JOT GHULIANI

Click on “Show/hide programs”, unselect “AuSCR Red”, and click on “Apply”, to display only the variables contained in the FeSS dataset.

Collect data
To prevent data loss your patient record edits are being automatically saved.

Auditor information

Hospital name: Apple Hospital
Auditor name: JOT GHULIANI

Show/hide programs
☐ AUSCR-RED-1
☒ AuSCR FeSS (Final)
 Apply

The colour indications on the section tabs indicate the completion status of all the programs that this client participates in.

In the screenshot below, although all the FeSS patient demographic variables are completed, the section tab remains amber, as the AuSCR patient demographic variables are incomplete.

Patient record edit

Record attributes
 Patient record ID: 191177
 Name: Mobile PHONE
 Admission date: 01/09/2018

Collect data
To prevent data loss your patient record edits are being automatically saved.

Patient demographics

First name: Mobile
 Last name: PHONE
 Date of birth: 26/04/1948
 Age: 70
 Gender: Female

Return to view

Click on the section tabs and complete all the data fields.

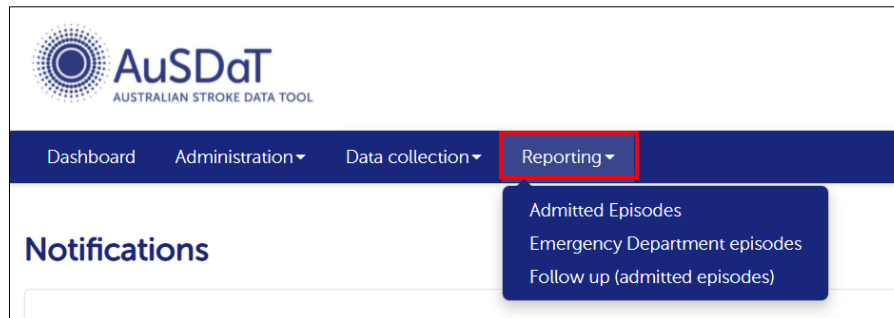
If the AuSCR record is complete, only a further six variables (listed in the “Other clinical information” section) will require data for the FeSS record to be completed.

REPORTS AND DATA EXTRACTION

HOSPITAL REPORTS

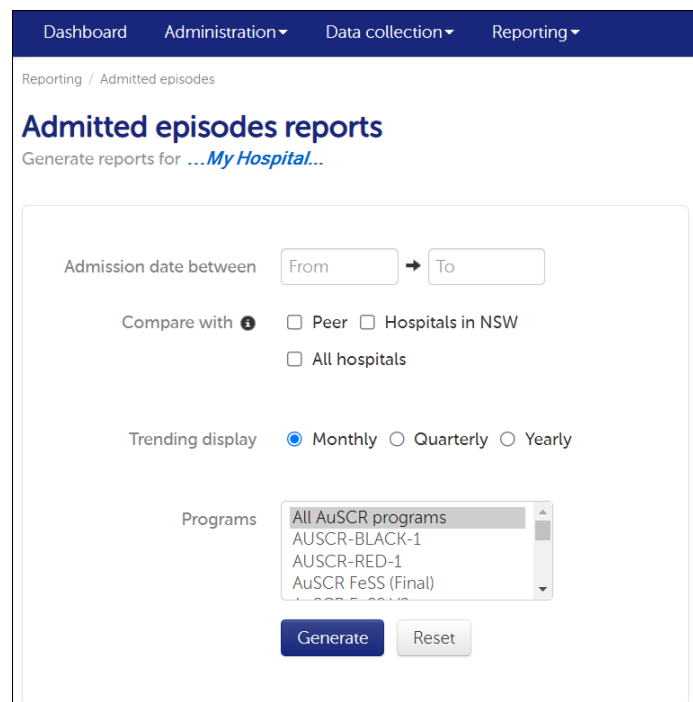
A variety of hospital summary data reports are available for AuSCR users to track their hospital's records on the AuSCR. These reports are “live” – they show the current data from your site. Note that the data may not have been verified or checked by the AuSCR Management Team and should be used internally only.

From the Dashboard, click on “Reporting”, and then select the required episodes report.




Depending on which data you want in your report, you can:

- Select a range of admission dates;
- Check categories of comparison with other hospitals (or uncheck if you only want data for your hospital);
- Select a timeframe for data trending breakdowns;
- Select AuSCR program (if applicable);
- Click Generate.



You can then select which category of report you would like to see:

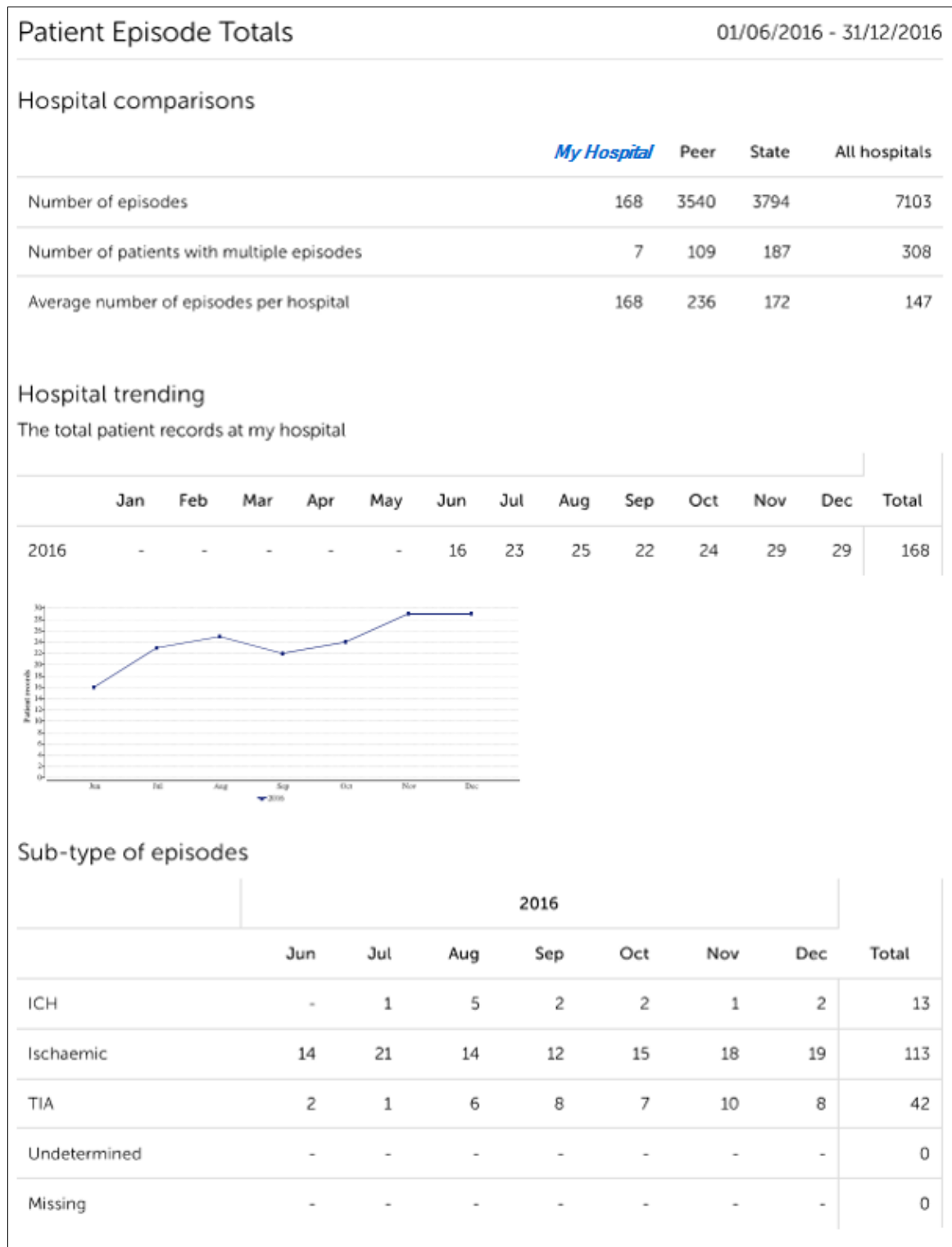
	
Patient Episode Totals	Patient Episode Totals
Patient Record Characteristics	Hospital comparisons
Processes of Care	
FeSS Processes of Care	Number of episodes
Discharge Information	Number of patients with multiple episodes
Thrombolysis and telemedicine	Average number of episodes per hospital
Clot retrieval	

SAMPLE PATIENT RECORD REPORTS

Note: the following samples are the first page only of each report. Hospitals have been de-identified.

ADMITTED EPISODES REPORTS

1) Patient Episode Totals



2) Patient Record Characteristics

Patient Record Characteristics

01/06/2016 - 31/12/2016

MyHospital Hospital data

	Missing	All cases	TIA	Ischaemic	ICH	Undetermined
Number of episodes by stroke type	0	168	42	113	13	0
Age in years	0					
Median		70	68	71	71	-
25th percentile		62	61	62	68	-
75th percentile		78	77	79	83	-
Sex n (%)	0					
Male	0	75 (56.4%)	25 (33.3%)	43 (57.3%)	7 (9.3%)	0 (0.0%)
Female	0	57 (42.9%)	13 (22.8%)	41 (71.9%)	3 (5.3%)	0 (0.0%)
Intersex	0	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Not stated	0	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Other characteristics n (%)						
Previous stroke	0	33 (19.6%)	4 (9.5%)	27 (23.9%)	2 (15.4%)	0 (0.0%)
Patients transferred from another hospital	0	38 (22.6%)	3 (7.1%)	28 (24.8%)	7 (53.8%)	0 (0.0%)

3) Processes of Care

Processes of Care		01/06/2016 - 31/12/2016									
		<i>My Hospital</i>			Peer Hospital			State			
		n	N	%	n	N	%	n	N	%	n
Stroke Unit care	Yes	114	168	67.9%	2501	3540	70.6%	2534	3784	67.0%	4806
	No/Unknown	54		32.1%	655		18.5%	966		25.5%	1803
	Missing	0		0.0%	384		10.8%	284		7.5%	483
tPA for Ischaemic strokes	Yes	5	113	4.4%	375	2063	18.2%	207	2170	9.5%	565
	No/Unknown	108		95.6%	1607		77.9%	1961		90.4%	3524
	Missing	0		0.0%	81		3.9%	2		0.1%	96
Arrival by ambulance	Yes	128	168	76.2%	2326	3540	65.7%	2443	3784	64.6%	4625
	No/Unknown	28		16.7%	524		14.8%	834		22.0%	1482
	Missing	12		7.1%	690		19.5%	507		13.4%	985
Aspirin in less than 48h (excludes ICH)	Yes	101	155	65.2%	869	3096	28.1%	1772	3342	53.0%	2454
	No/Unknown	48		31.0%	692		22.4%	814		24.4%	1493
	Contraindicated	2		1.3%	71		2.3%	91		2.7%	163
	Other antithrombotic agent	3		1.9%	352		11.4%	341		10.2%	690
	Missing	1		0.6%	1112		35.9%	324		9.7%	1486
Oral screen before medications	Yes	77	168	45.8%	1308	3540	36.9%	1956	3784	51.7%	2891
	No/Unknown	91		54.2%	723		20.4%	1455		38.5%	2286
	Missing	0		0.0%	1509		42.6%	373		9.9%	1913

4) FeSS Processes of Care

Processes of Care (FeSS Variables)

01/01/2020 - 01/01/2021

AuSCR FeSS

		My Hospital			Peer Hospital			State			All		
		n	N	%	n	N	%	n	N	%	n	N	%
Fever													
Was temperature recorded at least four times on day one of ward admission?	Yes	1	2	50.0%	1	2	50.0%	1	2	50.0%	1	494	0.2%
	No	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Not Documented	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Missing	1		50.0%	1		50.0%	1		50.0%	493		99.8%
In the first 72 hrs following admission did the patient develop a fever of greater or equal to 37.5C?	Yes	1	2	50.0%	1	2	50.0%	1	2	50.0%	1	494	0.2%
	No	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Not Documented	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Missing	1		50.0%	1		50.0%	1		50.0%	493		99.8%
If yes, was paracetamol administered within 1 hour of the FIRST elevated temperature (greater or equal to 37.5C)?	Yes	0	1	0.0%	0	1	0.0%	0	1	0.0%	0	1	0.0%
	No	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Contraindicated	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Already received regular paracetamol	1		100.0%	1		100.0%	1		100.0%	1		100.0%
	Not Documented	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Missing	0		0.0%	0		0.0%	0		0.0%	0		0.0%
Hyperglycaemia													
Was a finger-prick blood glucose level recorded at least four times on day one of ward admission?	Yes	1	2	50.0%	1	2	50.0%	1	2	50.0%	1	494	0.2%
	No	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Not Documented	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Missing	1		50.0%	1		50.0%	1		50.0%	493		99.8%
In the first 48 hours following ward admission did the patient develop a finger-prick glucose level of greater or equal to 10mmols/L?	Yes	0	2	0.0%	0	2	0.0%	0	2	0.0%	0	494	0.0%
	No	1		50.0%	1		50.0%	1		50.0%	1		0.2%
	Not Documented	0		0.0%	0		0.0%	0		0.0%	0		0.0%
	Missing	1		50.0%	1		50.0%	1		50.0%	493		99.8%
If yes, was insulin administered within 1 hour of the FIRST elevated finger prick glucose (greater or equal to 10mmol/L)?	Yes	-	-	0.0%	-	-	0.0%	-	-	0.0%	-	-	0.0%
	No	-		0.0%	-		0.0%	-		0.0%	-		0.0%

5) Discharge Information

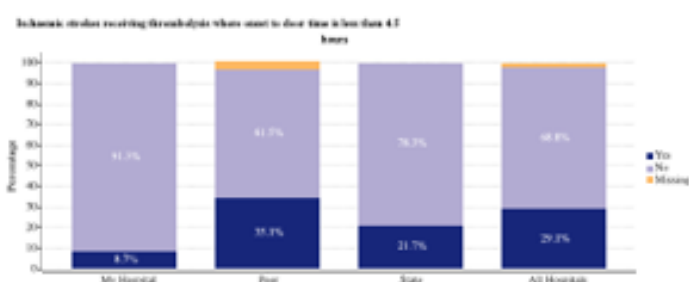
Discharge information							01/06/2016 - 31/12/2016
Length of stay – My hospital							
	Missing	All cases	TIA	Ischaemic	ICH	Undetermined	
Number of episodes	0	168	42	113	13	-	
Length of stay (days)	6*						
Mean		5	3	6	8	-	
SD		4	2	5	6	-	
Median		4	2	4	7	-	
25th percentile		2	1	3	4	-	
75th percentile		7	3	7	9	-	
Length of stay – Peer comparisons							
	Missing	All cases	TIA	Ischaemic	ICH	Undetermined	
Number of episodes	531	3540	410	2063	444	92	
Length of stay (days)	519*						
Mean		6	3	7	10	6	
SD		9	6	8	13	10	
Median		4	2	5	6	4	
25th percentile		2	1	3	3	2	
75th percentile		8	3	8	12	7	
Length of stay – State comparisons							
	Missing	All cases	TIA	Ischaemic	ICH	Undetermined	
Number of episodes	306	3784	763	2170	442	103	

6) Thrombolysis and telemedicine

Thrombolysis and use of telemedicine consultations 01/06/2016 - 31/12/2016

Thrombolysis

		<i>My Hospital</i>			Peer Hospital			State			All hospitals	
Question		n	N	%	n	N	%	n	N	%	n	N
All strokes receiving thrombolysis (excluding TIA)	Yes	5	126	4.0%	378	3130	12.1%	208	3021	6.9%	571	5866
	No/Unknown	118		93.7%	1855		59.3%	2386		79.0%	4130	
	Missing	3		2.4%	897		28.7%	427		14.1%	1165	
Ischaemic strokes receiving thrombolysis	Yes	5	113	4.4%	375	2063	18.2%	207	2170	9.5%	565	4185
	No/Unknown	108		95.6%	1607		77.9%	1961		90.4%	3524	
	Missing	0		0.0%	81		3.9%	2		0.1%	96	
Ischaemic strokes receiving thrombolysis where onset to door time is less than 4.5 hours	Yes	4	46	8.7%	307	875	35.1%	170	782	21.7%	459	1576
	No/Unknown	42		91.3%	538		61.5%	612		78.3%	1085	
	Missing	0		0.0%	30		3.4%	0		0.0%	32	



7) Clot retrieval

Endovascular clot retrieval

01/01/2020 - 31/12/2020

ECR treatment

		My Hospital			All hospitals		
		n	N	%	n	N	%
Ischaemic strokes receiving ECR	Yes	6	14	42.9%	259	1700	15.2%
	No/Unknown	7		50.0%	1435		84.4%
	Missing	1		7.1%	6		0.4%
Total number receiving ECR transferred from another hospital		2			77		
ECR cases							
Median age		4			73.5		
% male		66.7%			55.0%		
Median NIHSS on presentation		3			5		

Final thrombolysis in cerebral infarction (TICI) score (%)

	Score	Training Hospital	All hospitals
No anterograde flow	0	0.0%	1.5%
Flow past the initial occlusion but no tissue reperfusion	1	33.3%	1.5%
Partial tissue reperfusion in <50% of the occluded artery territory	2A	33.3%	7.0%
Partial tissue reperfusion in >=50% of the occluded artery territory but less than 2c	2B	0.0%	22.0%
Near-complete reperfusion except for slow flow in a few distal cortical vessels or presence of small distal cortical emboli (estimated >90% reperfusion)	2C	33.3%	31.0%
Complete reperfusion with normal filling of all distal branches	3	0.0%	37.0%

Emergency Department (ED) Report		01/01/2020 - 01/01/2021		
Patient characteristics				
	My Hospital	State	All	
Number of episodes	53	53	69	
Age (median)	70	70	68	
Gender				
Male (%)	29 (54.7%)	29 (54.7%)	39 (56.5%)	
Female (%)	23 (43.4%)	23 (43.4%)	29 (42.0%)	
Intersex (%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	
Not stated (%)	1 (1.9%)	1 (1.9%)	1 (1.4%)	
Stroke Type				
ICH	9 (18.0%)	9 (18.0%)	14 (21.5%)	
Ischaemic	40 (80.0%)	40 (80.0%)	50 (76.9%)	
TIA	0 (0.0%)	0 (0.0%)	0 (0.0%)	
Undetermined	1 (2.0%)	1 (2.0%)	1 (1.5%)	
Missing	3	3	4	
Stroke severity NIHSS				
0 - No stroke symptoms	2 (4.9%)	2 (4.9%)	3 (5.9%)	
1-4 Minor stroke	8 (19.5%)	8 (19.5%)	9 (17.6%)	
5-15 Moderate stroke	23 (56.1%)	23 (56.1%)	30 (58.8%)	
16-20 Moderate to severe stroke	3 (7.3%)	3 (7.3%)	4 (7.8%)	
21-42 Severe stroke	5 (12.2%)	5 (12.2%)	5 (9.8%)	
Median	10	10	11	
Unknown	10	10	15	
Missing	2	2	3	
Ability to walk at arrival to hospital				

Follow-up

01/01/2020 - 01/02/2021

Data in this report relate to completed surveys obtained from eligible registrants.

Follow-up information

Alive 100.0%

Deceased 0.0%

All participants from my hospital

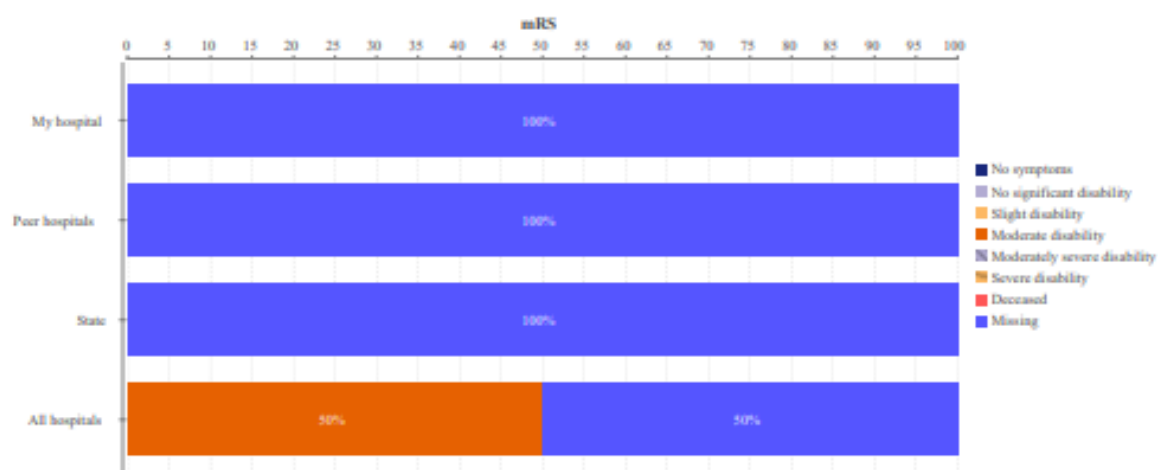
Number of follow-ups attempted 14

Number of follow-ups completed, n 1


Median time to follow-up (days) 232

Modified Rankin Scale (%)

	My hospital	Peer hospitals	State	All hospitals
0: No symptoms	0.0%	0.0%	0.0%	0.0%
1: No significant disability	0.0%	0.0%	0.0%	0.0%
2: Slight disability	0.0%	0.0%	0.0%	0.0%
3: Moderate disability	0.0%	0.0%	0.0%	50.0%
4: Moderately severe disability	0.0%	0.0%	0.0%	0.0%
5: Severe disability	0.0%	0.0%	0.0%	0.0%
6: Deceased	0.0%	0.0%	0.0%	0.0%
9: Missing	100.0%	100.0%	100.0%	50.0%



These reports can be printed or saved as a PDF by pressing the print button.



Print

Patient Episode Totals
Patient Record Characteristics
Processes of Care
FeSS Processes of Care
Discharge Information
Thrombolysis and telemedicine
Clot retrieval

Patient Episode Totals

01/01/2020 - 01/02/2021

Hospital comparisons

	Training Hospital	Peer	State	All hospitals
Number of episodes	33	62	34	2999
Number of patients with multiple episodes	1	1	1	162
Average number of episodes per hospital	33	31	17	130

Extra notes on Patient Record Reports

- Peer hospitals are grouped by the number of acute stroke admissions per year, as recorded in the Stroke Foundation acute audit organisational survey:
 - < 75 episodes
 - 75 to 199 episodes
 - 200 to 350 episodes
 - > 350 episodes.
- For hospitals that do not collect selected variables, these will still appear in the reports, with blank or zero entries for those variables.
- For hospitals which do not participate in the AuSCR FeSS program, the swallowing section of the FeSS Processes of Care report will still be generated using data from your AuSCR program.
- Hospitals which do not participate in the AuSCR Emergency Department program will not be able to generate an Emergency Department report.

Emergency Department (ED) reports

Generate reports for AUSCR-HOSPITAL

ED reporting in AuSDaT is only available for hospitals participating in the AuSCR-ED program.

ED arrival date between

From

→

To

Compare with ⓘ
☐ Peer
☐ Hospitals in VIC
☐ All hospitals

Trending display
☒ Monthly
☐ Quarterly
☐ Yearly

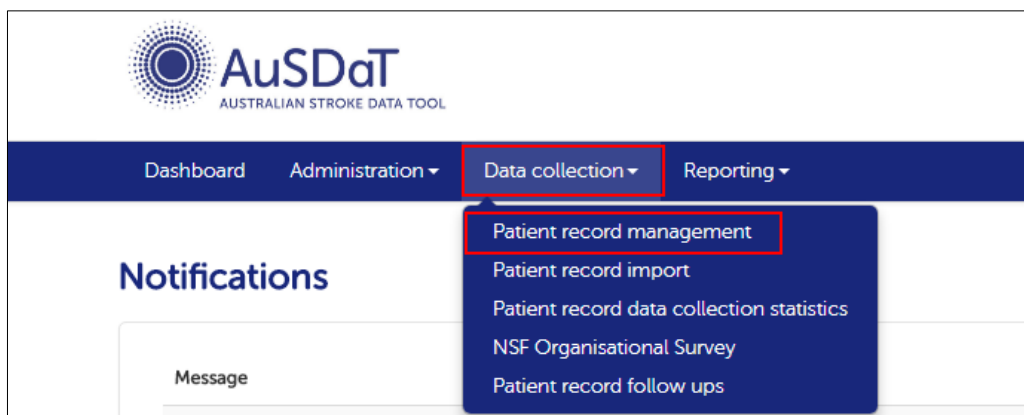
Generate

Reset

EXTRACTING ACUTE DATA

Hospitals can export either a sample or all of their acute AuSCR data. Records can only be exported for a single program at a time.

From the Dashboard, select “Data collection” and “Patient record management”.



Click on the relevant program tab, which will enable the green “Export” button on the search screen.

 This screenshot displays the 'Patient record management' interface. At the top, there's a header with the AuSDaT logo and user information: 'Welcome, JOT GHULIANI', 'Last Login: 17/07/2017 12:16', and 'Current Hospital: AUSCR-HOSPITAL'. The navigation bar includes 'Dashboard', 'Administration', 'Data collection', and 'Reporting'. Below this, a breadcrumb trail shows 'Data collection / Patient record management'. The main heading is 'Patient record management', followed by a 'New record' button. A series of tabs represent different programs: 'All', 'AUSCR-BLACK-1' (highlighted with a red box), 'AUSCR-BLUE-1', 'AUSCR-GREEN-1', 'AUSCR-MAROON-1', 'AUSCR-PURPLE-1', 'AUSCR-RED-1', 'AuSCR-RED-migrate', 'BEEPRS', 'BLACK-migrate', and 'GREEN-migrate'. A search form titled 'Go to patient record' contains an 'ID' field and a 'Go' button. Below this is a 'Search for patient records' section with fields for 'First name', 'Last name', 'Gender' (a dropdown menu), and 'Date Of Birth'. A link to 'Show advanced search options' is present, along with 'Search' and 'Reset' buttons. At the bottom, there's a 'Show 10 entries' dropdown and two buttons: 'Export...' (highlighted with a red box) and 'Bulk update'.

To export your entire data set, simply click on the Export button (note: this may take some time, depending on how many records the hospital has). Alternatively, select a range of admission dates from the Advanced Search options (or other search criteria) and click on “Search” for a subset of records.

Search for patient records:

First name

Last name

Gender

Date Of Birth

Admission date 01/01/2016 → 30/04/2016

Date created From → To

MRN

State

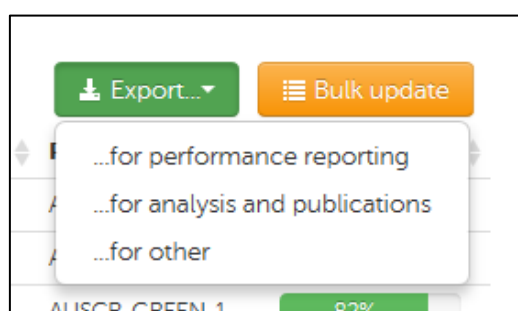
Opt-out

Opt-out date From → To

▲ Hide advanced search options

Show 10 entries

Then click the green “Export” button, and select the reason that you are exporting the data. In most cases it would be “....for analysis and publications”.



There is no difference in the format of the file that is downloaded, however the option chosen is stored in the database and used for auditing purposes.

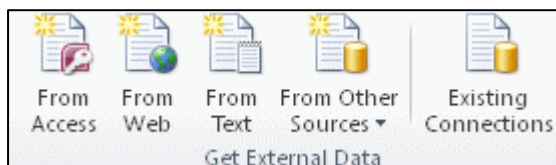
Your report will be generated and a link will appear for you to open or save the file.

	A	B	C	D	E	F	G	H	I	J	K	L
1	Patient record ID	SLK	Hospital ID	Import ID	Date/time created	Date/time updated	Status	Date of last status transition	Opt-out	Opt-out Date	Refused follow-up	Deceased Date
2												
3	48663	ICEAU280719812	229		15/08/2016 2:14	15/08/2016 2:27	Open	15/08/2016				
4	48666	IM2ET030719421	229		15/08/2016 3:06	15/08/2016 3:26	Open	15/08/2016				
5	48870	ILSAR250319362	229		19/08/2016 2:12	19/08/2016 2:29	Open	19/08/2016				
6	48858	PIVND300319411	229		18/08/2016 2:45	18/08/2016 3:27	Open	18/08/2016				
7	48664	TARGET200819272	229		15/08/2016 2:29	15/08/2016 3:00	Open	15/08/2016				
8	Number records	5	Date exported	16/09/2016 12:37								

Data exports from the AuSDaT are in CSV format. In general, the files can be opened in Excel to filter the data and use it to create graphs and tables if required. Some variables, however, may not be reflected correctly because of the automatic formatting Excel applies to CSV files, e.g. omitting leading zeros on the Medical Record (UR) Number.

To resolve this issue, import the AuSCR exported CSV file into a blank excel workbook as an external data range using the following process.

1. Click the cell where you want to put the data from the AuSCR export file.
2. On the **Data** tab, in the **Get External Data** group, click **From Text**.



3. Locate and double-click the AuSCR export file that you want to import.

Follow these steps in the Text Import Wizard:

Step 1: Select the Delimited option and click Next.

Text Import Wizard - Step 1 of 3

The Text Wizard has determined that your data is Fixed Width.
If this is correct, choose Next, or choose the data type that best describes your data.

Original data type
Choose the file type that best describes your data:

☒ **Delimited** - Characters such as commas or tabs separate each field.
☐ **Fixed width** - Fields are aligned in columns with spaces between each field.

Start import at row: File origin:

☐ My data has headers.

Preview of file C:\Users\shehata\Documents\ausdat_export_20150810_153002-other.csv

1	Patient record ID,4,4.01,4.02,4.03,4.04,4.14,4.15,4.16,4.17,4.18,4.181,4.
2	,Onset date,Unknown,Date accuracy,Onset time,Time accuracy,Did the stroke
3	786,,
4	788,,,,,,,,,,,,,,,,,,,,,,,,10/08/2015,,
5	789,10/08/2015,FALSE,AAA,13:00,KWN,9,,,,,FALSE,,9,,TRUE,,FALSE,EAA,10/08/

Buttons: Cancel, < Back, **Next >**, Finish

Step 2: Select the Comma option and deselect Tab (the default setting), and click Next.

Text Import Wizard - Step 2 of 3

This screen lets you set the delimiters your data contains. You can see how your text is affected in the preview below.

Delimiters

☐ Tab
☐ Semicolon
☒ **Comma**
☐ Space
☐ Other:

☐ Treat consecutive delimiters as one

Text qualifier:

Data preview

Patient record ID	4	4.01	4.02	4.03	4.04
	Onset date	Unknown	Date accuracy	Onset time	Time accuracy
786					
788					
789	10/08/2015	FALSE	AAA	13:00	KWN

Buttons: Cancel, < Back, **Next >**, Finish

Step 3: Using the scroll bar at the bottom of the screen, navigate to each field you wish to reformat and select the appropriate data format for each field. Our recommendation is to reset the following fields to TEXT format:

- 2.12: Hospital Medical Record Number (MRN)
- 14.152: What is the Medical Condition ICD-10 Classification Code?
- 14.153: What is the Medical Complication ICD-10 Classification Code?
- 14.152: What is the Medical Procedure ICD-10 Classification Code?

Text Import Wizard - Step 3 of 3

This screen lets you select each column and set the Data Format.

Column data format

☐ General

☒ Text

☐ Date: DMY

☐ Do not import column (skip)

'General' converts numeric values to numbers, date values to dates, and all remaining values to text.

Advanced...

Data preview

General	Text	General
(specify)	14.152	14.153
	What is the Medical Condition ICD 10 Classification Code?	What is

Cancel < Back Next > Finish

When you are done with the steps in the wizard, click **Finish** to exit the Text Import Wizard.

4. In the **Import Data** dialog box, optionally click **Properties** to set refresh, formatting, and layout options for the imported data, then under **Where do you want to put the data?** Select **Existing worksheet** or **New worksheet** as required, then click **OK**.

If you have any further queries about manipulating your hospital's AuSCR data in Excel, please contact the AuSCR Office.

VIEWING AND EXTRACTING FOLLOW-UP DATA

The AuSCR office follows up stroke patients three to six months after their stroke. Data Collectors do not have access to follow-up data, but Hospital Coordinators can view and export their follow-up data as required. The processes are very similar to those for acute data as outlined above.

For viewing or exporting follow-up data, from the Dashboard, select "Data collection" and "Patient record follow ups", then you can select individual patient records to view, or search on a range of admission dates or a specific follow-up status to export via the green Export button. Make sure you select a single program tab to enable the Export button.

Patient record follow ups

Generate follow ups Bulk update attempts

All BLACK-migrate GREEN-migrate RED-migrate AUSCR-GREEN-1 AUSCR-BLUE-1 AUSCR-PURPLE-1 AUSCR-MAROON-1 AUSCR-BLACK-1 AUSCR-RED-1

Go to follow up

ID

Search for follow ups:

Patient record ID

First name

Last name

Admission date From To

Hospital

Date added From To

Follow-up status

Show entries

ID	Patient record ID	First name	Last name	Admission date	Hospital	Date added	Follow-up status
1880	7964	6ea2f9e386f2f6e	F08915432281847	01/03/2016	AUSCR-HOSPITAL	07/06/2016	In progress
1879	7960	optout	PROGRAM1	01/02/2016	AUSCR-HOSPITAL	07/06/2016	In progress
1722	7963	nick	FOLLOW	01/02/2016	AUSCR-HOSPITAL	06/06/2016	In progress
1721	7949	a33d7d57765ae2a	32aa463edf9c57c	27/03/2016	AUSCR-HOSPITAL	06/06/2016	Completed

Exported follow-up data, like AuSCR acute data, is coded. See Appendix 2: Interpreting follow-up data for a guide to the codes used.

For summary reports of follow-up data, from the Dashboard, click on Reporting – Follow up, then select parameters for your report.

Follow up reports

Generate reports for AUSCR-HOSPITAL

Admission date between →

Compare with ☐ Peer ☐ Hospitals in VIC ☒ All hospitals

Trending display ☒ Monthly ☐ Quarterly ☐ Yearly

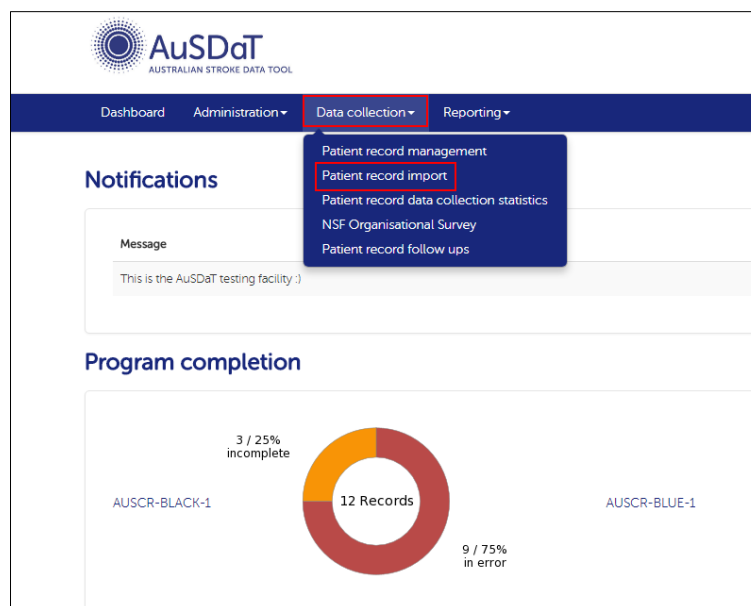
Click Generate to see the summary report data. This can be printed or saved as a PDF by clicking the Print button.

PATIENT RECORD IMPORTS

For hospitals wishing to import data directly from their Patient Administrative Systems (PAS), you will need to match your data extraction process with the appropriate data import template for your hospital's AuSCR program.

Please note that, whether data is entered manually in the template or transferred from a PAS or other database, the fields need to be entered in exactly the correct format as indicated at the top of the template (e.g. all capitals for some fields, coded numbers for others.) Contact your relevant AuSCR Data Manager for help mapping data elements to the correct AuSCR field on the import template.

From the Dashboard, select "Data Collection", "Patient record import":



Then click on "New import":



Select the appropriate AuSCR program and click on "Generate import template":

AuSDaT
AUSTRALIAN STROKE DATA TOOL

Dashboard Administration Data collection Reporting

Data collection / Patient record import / New import

New import

Select programs to generate your import template

Program(s)

- ☐ AUSCR-BLUE-1
- ☐ AUSCR-PURPLE-1
- ☐ AUSCR-MAROON-1
- ☐ AUSCR-BLACK-1
- ☒ AUSCR-GREEN-1
- ☐ GREEN-migrate
- ☐ AuSCR-RED-migrate
- ☐ BLACK-migrate
- ☐ BEEPRS
- ☐ AUSCR-RED-1

Generate import template Cancel

Open and populate this file with your patient data, making sure that each column matches the correct heading. Then save your data import file in a safe place on your computer. We recommend that you save all your data import files in the same subfolder, with a name that includes the date of import and the initials of the staff member who imported it, for future reference.

Once you have your data import file ready, from the Dashboard, select “Data collection”, “Patient record import”, and click on your most recent Import ID (with a status of “Pending”).

Note: you may need to click on “Created date” to sort the imports so that the most recent one is at the top of the list.

Dashboard Administration Data collection Reporting

Data collection / Patient record import

Patient record import

New import

Search for imports:

Imported date From To

Created date From To

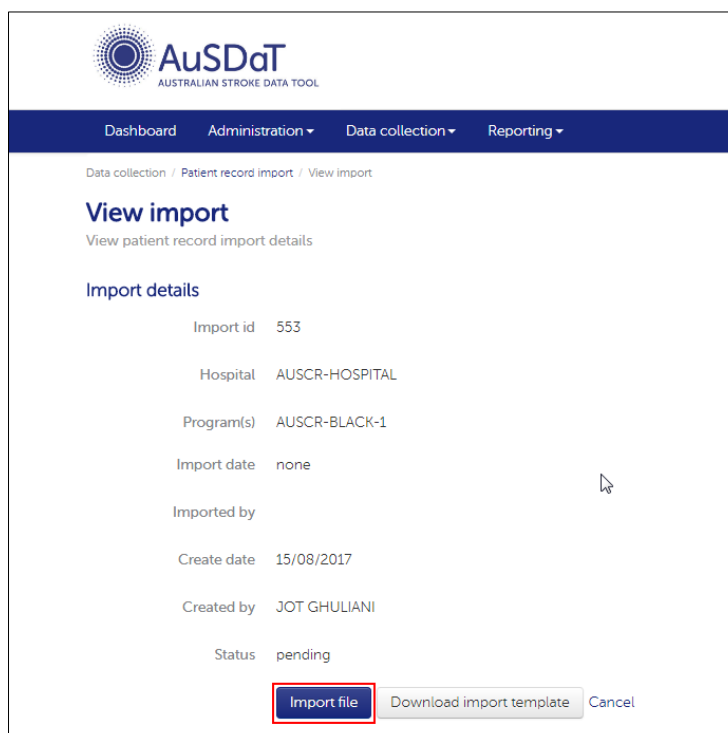
Status Status

Search Reset

Show 10 entries

Import id	Program(s)	Imported date	Imported by	Created date	Status
553	AUSCR-BLACK-1	none		15/08/2017	Pending
552	AUSCR-BLACK-1	none		15/08/2017	Pending
551	AUSCR-BLACK-1	15/08/2017	KATE PAICE	15/08/2017	Complete
550	AUSCR-BLACK-1	none		15/08/2017	Error

Click on “Import file”



AuSDaT
AUSTRALIAN STROKE DATA TOOL

Dashboard Administration Data collection Reporting

Data collection / Patient record import / View import

View import

View patient record import details

Import details

Import id 553

Hospital AUSCR-HOSPITAL

Program(s) AUSCR-BLACK-1

Import date none

Imported by

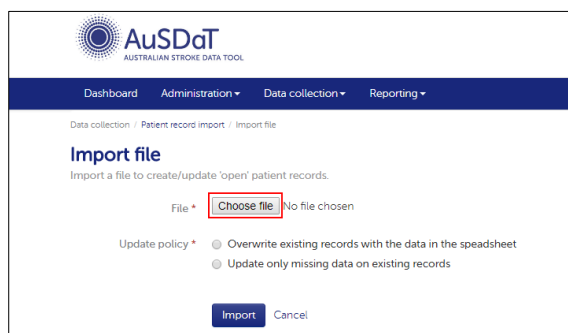
Create date 15/08/2017

Created by JOT GHULIANI

Status pending

Import file Download import template Cancel

From the Import file screen, select your data import file. Depending on which browser you are using, you will select your file by clicking on “Choose file” or “Browse”.



AuSDaT
AUSTRALIAN STROKE DATA TOOL

Dashboard Administration Data collection Reporting

Data collection / Patient record import / Import file

Import file

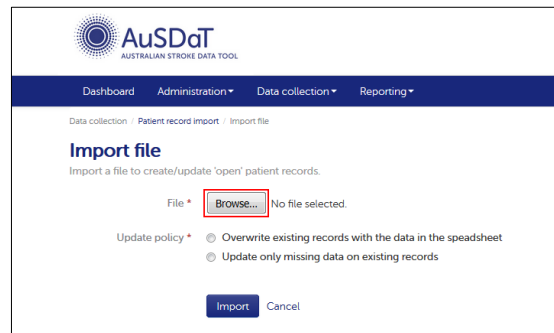
Import a file to create/update 'open' patient records.

File * **Choose file** No file chosen

Update policy *

- ☒ Overwrite existing records with the data in the spreadsheet
- ☐ Update only missing data on existing records

Import Cancel



AuSDaT
AUSTRALIAN STROKE DATA TOOL

Dashboard Administration Data collection Reporting

Data collection / Patient record import / Import file

Import file

Import a file to create/update 'open' patient records.

File * **Browse...** No file selected.

Update policy *

- ☒ Overwrite existing records with the data in the spreadsheet
- ☐ Update only missing data on existing records


Import Cancel

You will also need to select from the options:

- Overwrite any existing data in the AuSCR with your new data; or
- Update only missing data: this will only import fields that are currently empty; if any other data is different to what already exists in the AuSCR, it will not be changed.

In most cases, you would usually select Overwrite, but there may be cases where you want to protect existing data from being changed, and only add extra data to what is currently missing. In this case, select Update only missing data on existing records.

Then click on “Import” to process your file.


AuSDaT
 AUSTRALIAN STROKE DATA TOOL

Dashboard Administration ▾ Data collection ▾ Reporting ▾

Data collection / Patient record import / Import file

Import file

Import a file to create/update 'open' patient records.

File * Choose file patient_record_i...2017 test 2.xlsx

Update policy *

☒ Overwrite existing records with the data in the spreadsheet

☐ Update only missing data on existing records

Import

Cancel

Once the import process is completed, you can select the Import ID number and view all the patient records imported in the process.

View import

View patient record import details

Import details

Import id 370
 Hospital AUSCR-HOSPITAL
 Program(s) AUSCR-GREEN-1
 Import date 22/06/2016
 Imported by HELEN CARTER
 Create date 22/06/2016
 Created by HELEN CARTER
 Status complete

Download import template
Cancel

Patient records imported

Show 10 v entries
Search:

Patient Episode Ref	First name	Last name	Gender	Date Of Birth	Admission date	Date created	Completeness
116707	Minerva	McGonagall	Female	06/06/1913	04/02/2016	22/06/2016	59%
116706	Molly	Weasley	Female	05/05/1932	03/02/2016	22/06/2016	59%
116705	Severus	Snape	Male	04/04/1931	02/02/2016	22/06/2016	58%
116704	Ron	Weasley	Male	01/02/1940	01/02/2016	22/06/2016	58%

Showing 1 to 4 of 4 entries

Australian Stroke Data Tool (AuSDaT)

Terms and Conditions for Users

BACKGROUND

The Australian Stroke Data Tool (**AuSDaT**) is an online, integrated data management system for monitoring the quality of stroke care. The AuSDaT is operated by a collaboration of four organisations (the AuSDaT Collaboration) to enable shared responsibilities for the collaborative development and operation of the AuSDaT in accordance with an interparty agreement between the National Stroke Foundation; the Florey Institute of Neuroscience and Mental Health; Hunter Medical Research Institute; and the Stroke Society of Australasia.

The initial build of the AuSDaT was funded by the National Stroke Foundation with cash and in-kind contributions from the Florey Institute of Neuroscience and Mental Health (Florey). A Steering Committee (Australian Stroke Coalition Data and Quality Committee) oversees the governance of the AuSDaT and maintains the confidence of all parties involved. The operation of the AuSDaT is managed by the AuSDaT Coordinating Committee whose members include representatives from the programs involved in using the AuSDaT. There is an appointed AuSDaT Data Custodian, National Coordinator, Data Manager and Systems Administrator to conduct the day-to-day activities associated with the AuSDaT according to agreed policies and procedures.

User organisations will retain ownership of any of their data submitted to AuSDaT and authorised users can access and export such data at any point using the functionality in AuSDaT. User organisations agree to share, without restriction, their data submitted into the AuSDaT for the Agreed Purpose.

A Glossary is provided at the end of this document with definitions of terminology as used in these Terms and Conditions.

TERMS and CONDITIONS

You must not click “I agree” (or use AuSDaT in any manner) unless you have been authorised by your organisation to be an authorised user who is able to agree to these Terms and Conditions.

By clicking “I agree” (and in consideration of the AuSDaT Coordinating Committee providing your organisation with the right to access and use AuSDaT, as set out in this document), you agree to the Terms and Conditions set out below and must ensure you comply with these Terms and Conditions. Failure to comply with these Terms and Conditions may result in you, or your organisation, being excluded from further use of AuSDaT.

The AuSDaT Collaboration and User agree that:

1. These Terms and Conditions take effect on the date that they are accepted by clicking “I agree”, and continue until they are terminated in accordance with Clause 22.
2. The AuSDaT Collaboration owns all rights (including any intellectual property rights) in AuSDaT and grants Users a right to access and use AuSDaT for the Agreed Purpose only.
3. The User agrees that they will adhere to all relevant policies and procedures for the AuSDaT including the User Manual, National Stroke Data Dictionary (NSDD) and in activities related to data collection, data quality, data export and upload, use of live reports and analysis and reporting of data extracted from AuSDaT.
4. The data entered into AuSDaT by a User may be used by the AuSDaT Collaboration for the Agreed Purpose and in accordance with AuSDaT, Program or Project policies and procedures and ethical clearances as required.
5. The AuSDaT is not intended to be used to make clinical decisions in place of primary source data (e.g. medical record) for individual patient care, and should not be used for this purpose by a User.
6. The User is responsible for ensuring that any data that they submit to AuSDaT:

- a. satisfies any minimum data requirements reasonably specified in the NSDD and relevant AuSDaT policies for ensuring data quality;
 - b. is correct, accurate, complete and up to date; and
 - c. is submitted:
 - i. according to governance clearances for the Programs or Projects to which your organisation is contributing; and
 - ii. otherwise in accordance with all applicable laws (including privacy laws).
7. Users must not knowingly, recklessly or negligently submit to, or amend, any data in AuSDaT that is deliberately inaccurate, false or misleading.
8. The User agrees to provide all reasonable assistance requested by the AuSDaT Data Custodian or delegate to undertake data quality assurance activities as required to comply with Clause 6.
9. The User must at all times maintain the security and confidentiality of their AuSDaT account(s) and password(s) details, and otherwise take all reasonable steps to protect AuSDaT from unauthorised access or use (including by any other individuals). The User is responsible for all activities that occur under their AuSDaT account(s) or password(s).
10. The AuSDaT Data Custodian or delegate may, without any liability to the Organisation or its personnel, suspend any or all access to, or use of, AuSDaT by a User if there is an actual, threatened or suspected breach of security, including any unauthorised access or use of a User's AuSDaT account or password.
11. A User must complete the National Stroke Foundation Organisational Survey on first login (if not already completed), which will remain within AuSDaT as a hospital's profile. If a hospital does not complete the survey, a hospital's user/s will not be able to access the tool to collect data for other Program/s or data collection Projects.
12. Users must collect data for the Agreed Purpose in a timely manner to ensure that no Program or Project is disadvantaged or data quality compromised (as per Clause 6).
13. A User agrees to be invited to participate in an evaluation of the AuSDaT if requested by the AuSDaT Coordinating Committee, the AuSDaT Data Custodian or delegate in order to assist with making improvements to the AuSDaT system.
14. The AuSDaT Coordinating Committee, the AuSDaT Data Custodian or delegate may suspend access to, and use of, AuSDaT in order to coordinate or perform scheduled maintenance and upgrade work on AuSDaT. Subject to Clause 15, they will:
 - a. use reasonable endeavours to ensure that planned system maintenance and upgrades are managed efficiently to minimise downtime; and
 - b. notify Users of scheduled maintenance and upgrade work through the AuSDaT Dashboard or alternative method.
15. The AuSDaT Coordinating Committee, the AuSDaT Data Custodian or delegate may interrupt or suspend all access to and use of AuSDaT (without any liability to a Participating Organisation or Users) if urgent repairs or maintenance are required, or it is required to interrupt or suspend access by law (including where required by any lawful direction of a regulator, court or other authority). Where reasonable and practicable, Participating Organisations or Users will be provided with prior notice of any such interruption or suspension.
16. The AuSDaT Data Custodian will use reasonable endeavours to ensure that any data submitted by Users is stored in a secure environment that complies with all applicable state and national legal obligations regarding the collection and storage of data.
17. Programs collecting data via the AuSDaT will provide reasonable assistance to train and support Users in the use of the tool for the Agreed Purpose.
18. The AuSDaT Coordinating Committee, the AuSDaT Data Custodian or delegate will, from time to time, provide communication regarding any evaluation and resultant enhancements to AuSDaT.
19. The AuSDaT will, unless otherwise notified, contain functionality to assist Users to maximise the usefulness of the data collected in informing quality improvement to address variations in clinical practice including reviewing reports derived in the AuSDaT or exporting data for local use.

20. The User acknowledges that AuSDaT is provided on an “as is” basis. The AuSDaT Collaboration makes no guarantees or representations:
- a. as to the availability or performance of AuSDaT;
 - b. about the completeness, accuracy or currency of any data that has been uploaded to AuSDaT by third parties (such as other Users or Participating Organisations); or
 - c. that AuSDaT will be error free.
21. The AuSDaT Collaboration (and each of their respective directors, officers, agents or employees) exclude all liability in contract or in tort (including in negligence) or otherwise for any liability, claims, cost, loss or damage (including indirect, special or consequential loss or damage) which may be suffered or incurred by Users as a direct or indirect result of their use of AuSDaT.
22. The AuSDaT Collaboration may, at any time, terminate these Terms and Conditions by giving the User 30 days’ written notice and may also terminate these Terms and Conditions immediately if:
- a. the User commits a material breach of these Terms and Conditions and that breach is not capable of remedy;
 - b. the User fails to remedy a material breach of these Terms and Conditions within 30 days after receiving written notice requiring the User to do so; or
 - c. AuSDaT is discontinued for any reason.
- The User may terminate these Terms and Conditions at any time by giving the AuSDaT Collaboration 30 days’ written notice.
23. Upon termination of these Terms and Conditions, the User must immediately cease all use and access of AuSDaT.
24. These Terms and Conditions may only be varied or replaced by a document executed by the AuSDaT Data custodian or delegate on behalf of the AuSDaT collaboration.
25. These Terms and Conditions are governed by and are to be construed in accordance with the laws applicable in Victoria, and the AuSDaT Collaboration and the User irrevocably and unconditionally submits to the non-exclusive jurisdiction of the courts of Victoria.
26. The User may not assign any, or all, of his/her rights and obligations under these Terms and Conditions to any other party, except with the prior written consent of the AuSDaT collaboration.
27. These Terms and Conditions are not intended to create a partnership, joint venture or agency relationship between the AuSDaT Collaboration and the User.

GLOSSARY

Agreed Purpose:	Defined within an AuSDaT organisational agreement outlining the Programs or Projects or data variables, available from the National Stroke Data Dictionary, to which the User will be contributing
AuSDaT:	Australian Stroke Data Tool
AuSDaT Collaboration:	Organisations that have signed the AuSDaT Interparty Agreement and hold the intellectual property and responsibility for the integrity of the system
AuSDaT Organisational Agreement:	A separate agreement between the AuSDaT Collaboration and the Participating Organisation that outlines which Programs or Projects or local customised dataset to which the organisation will contribute as part of using AuSDaT
Participating Organisation:	Health service, university, independent research institute or similar that will contribute data into AuSDaT for the Agreed Purpose
Program:	Ongoing data collection as part of a recognised activity e.g. Australian Stroke Clinical Registry
Project:	Time limited data collection as part of a recognised activity e.g. research project
NSDD:	National Stroke Data Dictionary
User:	Authorised user of the AuSDaT who has been issued a password to use the system

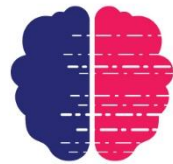
APPENDIX 2: INTERPRETING FOLLOW-UP DATA

This guide has been developed to assist hospital staff to interpret their hospital's AuSCR follow-up data exported from the AuSDaT.

MDL no.	Follow-up question <i>Coding used in extracts (description to match code)</i>
15.11	Would you like to receive an information package from the Stroke Foundation about stroke and support services? 1 (Yes) 2 (No)
15.12	Would you be willing to be contacted in the future to hear about possible stroke research projects that you may be eligible for? 1 (Yes) 2 (No)
15.19	Form completed by: 0 (Patient) 1 (Spouse/Partner) 2 (Son/Daughter) 3 (Other relative) 4 (Friend/associate) 5 (Professional carer) 6 (Sibling) 7 (Not stated)
15.2	Where are you staying at present? 0 (Missing) 1 (High level residential care) 2 (Low level residential care) 3 (Home with supports) 4 (Home without supports) 5 (Rehabilitation (inpatient)) 6 (Transitional care services) 7 (Hospital) 9 (Other)
15.21	Do you live on your own? 1 (Yes, I live entirely on my own) 2 (No, I live with others) 9 (Missing)
15.22	Since you were in hospital for your stroke, have you had another stroke? 1 (Yes) 2 (No) 9 (Unknown)
15.23	Since you were in hospital for your stroke, have you been readmitted to hospital? 1 (Yes) 2 (No) 9 (Unknown)
15.24	Date of readmission DD/MM/YYYY
15.25	Date of readmission accuracy AAA (Accurate) EAA (Estimate)
15.26	Reason for readmission 0 (Stroke) 1 (TIA) 2 (Acute coronary syndromes or myocardial infarcts) 3 (Coronary heart disease/heart failure and cardiomyopathy/rheumatic heart) 4 (Peripheral vascular disease) 5 (Blood and metabolic disorders) 6 (Cancer and other neoplasms)

	<p>7 (Chronic musculoskeletal disorders)</p> <p>8 (Endocrine disorders)</p> <p>9 (Gastrointestinal diseases)</p> <p>10 (Infections)</p> <p>11 (Injuries)</p> <p>12 (Kidney and urinary diseases)</p> <p>13 (Mental illnesses and behavioural disorders)</p> <p>14 (Neurological conditions)</p> <p>15 (Respiratory diseases)</p> <p>16 (Skin disorders)</p> <p>17 (Elective surgery/procedure)</p> <p>18 (Unknown)</p> <p>19 (Other)</p>
15.261	<p>Please specify (Enabled if 'Other' is selected for 15.26)</p> <p><i>Text field</i></p>
15.262	<p>Modified Rankin Score at 3 months post stroke</p> <p>0 (No Symptoms at all)</p> <p>1 (No Significant Disability Despite Symptoms [able to carry out all usual duties and activities])</p> <p>2 (Slight Disability [unable to carry out all previous activities, but able to look after own affairs without assistance])</p> <p>3 (Moderate Disability [requiring some help, but able to walk without assistance])</p> <p>4 (Moderately Severe Disability [unable to walk without assistance, and unable to attend to own bodily needs without assistance])</p> <p>5 (Severe Disability [bedridden, incontinent, and requiring constant nursing care and attention])</p>
15.27	<p>Thinking about your health today, which of the following statements best describes your mobility?</p> <p>1 (I have no problems in walking about)</p> <p>2 (I have some problems in walking about)</p> <p>3 (I am confined to bed)</p>
15.28	<p>Thinking about your health today, which of the following statements best describes your self-care?</p> <p>1 (I have no problems washing or dressing myself)</p> <p>2 (I have some problems washing or dressing myself)</p> <p>3 (I am unable to wash or dress myself)</p>
15.29	<p>Thinking about your health today, which of the following statements best describes your usual activities such as work, study, housework, family or leisure activities?</p> <p>1 (I have no problems doing my usual activities)</p> <p>2 (I have some problems doing my usual activities)</p> <p>3 (I am unable to do my usual activities)</p>
15.3	<p>Thinking about your health today, which of the following statements best describes any pain or discomfort you may be experiencing?</p> <p>1 (I have no pain or discomfort)</p> <p>2 (I have moderate pain or discomfort)</p> <p>3 (I have extreme pain or discomfort)</p>
15.31	<p>Thinking about your health today, which of the following statements best describes any anxiety and depression you may be experiencing?</p> <p>1 (I am not anxious or depressed)</p> <p>2 (I am moderately anxious or depressed)</p> <p>3 (I am extremely anxious or depressed)</p>
15.32	<p>What number between 0 and 100 best describes your health today?</p> <p>0-100</p> <p>999 (Unknown)</p>
15.33	<p>Is this a telephone interview?</p> <p>1 (Yes)</p> <p>2 (No)</p>

CONSORTIUM PARTNERS



**AUSTRALIAN STROKE
CLINICAL REGISTRY**
FACILITATING QUALITY



The Florey



AUSTRALIAN & NEW ZEALAND
STROKE
ORGANISATION



MONASH
University