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DATA QUALITY REPORT 2024

DECEMBER, 2025

AUSTRALIAN STROKE CLINICAL REGISTRY

FACILITATING QUALITY

This report was produced on behalf of the Australian Stroke Clinical Registry (AuSCR) Consortium partners and was approved by the AuSCR Operational and Quality Improvement Committee.

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Any enquires about, or comments on, this publication should be directed to:

Administration

Australian Stroke Clinical Registry Office

The Florey Institute of Neuroscience and Mental Health
245 Burgundy Street
Heidelberg, Victoria 3084,
Australia

Ph: 1800 673 053
Email: admin@auscr.com.au
Website: www.auscr.com.au
@AustStrokeReg

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CONSORTIUM PARTNERS

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INTRODUCTION

The Australian Stroke Clinical Registry (AuSCR) provides national data on high priority, evidence-based clinical care and outcomes for patients admitted to hospital with acute stroke. The primary purpose of the Registry is to provide reliable and representative data to improve the quality of stroke care in Australian hospitals. The quality of the data in the Registry is essential to its purpose.

Accountability for the accuracy and completeness of hospital data is the responsibility of the participating hospitals. However, it is the role of the AuSCR office to support hospitals to collect high quality data via education, training and feedback. Therefore, the combined efforts of hospitals and the AuSCR office ensures the most complete data for each annual reporting period. Hospitals participating in the AuSCR are encouraged to use this report alongside site-specific feedback provided throughout the year to improve data quality. Information on data quality is also available in the various data dashboards that are updated every day within the online data system.

This Data Quality Report covers data collected for patients admitted to participating hospitals between 1 January 2024 and 31 December 2024. It is supplementary to, and should be read in conjunction with, the corresponding Annual Report (https://auscr.com.au/about/annual-reports/).

METHODS FOR ENSURING DATA QUALITY

The AuSCR office undertakes a range of regular data checking and quality assurance procedures to support data quality.

Hospital users are encouraged to complete data within 90 days of a patient's admission, which is when the AuSCR office commences collection of patient-reported outcomes. Final 2024 data quality checks were completed in April and May 2025 and we requested all 2024 data be finalised by 31 May 2025. Data were extracted for linkage by the Australian Institute of Health and Welfare to the National Death Index on 3 June 2025. Information on deaths were included in the AuSCR and final data extracted for this report on 16 September 2025.

DATA PLATFORM DATA QUALITY FEATURES

Since July 2016, the collection of AuSCR data by staff at participating hospitals has been facilitated in the Australian Stroke Data Tool (AuSDaT, https://australianstrokecoalition.org.au/projects/ausdat/).1 The AuSDaT contains in-built functions to auto-check the logic of manually entered data to minimise the potential for inaccurate or discrepant data during data entry. In AuSDaT there is also the function to search for incomplete records and records with data errors. New data dashboards released in 2023 and 2024 also support routine checking for erroneous data.

DATA CHECKS BEFORE IMPORT

Where data exports from hospital systems are supplied in separate files via secure cloud data sharing (SharePoint, Microsoft 365 suite) for import into the AuSDaT, these files are reviewed by AuSCR Data Managers prior to upload. This centralised process is used to ensure the data are in the correct format and provide an opportunity for any inconsistent or erroneous data to be corrected prior to performing the import. Hospital staff who import their own data into the AuSDaT can also request the AuSCR Data Managers check for errors prior to import into the registry platform.

Case ascertainment

Assessment for completeness of case ascertainment is an essential process for ensuring that the data recorded in the AuSCR are representative of the patient population with stroke admitted to each participating hospital. It is a requirement for all clinical registries to collect and report this information.2 Case ascertainment results provide an indication of the representativeness of data and whether there are any potential selection biases in the patient sample.

Consistent with the process in 2023, in 2024 only episodes where the stroke ICD-10 (International Statistical Classification of Diseases 10th revision) code was the principal diagnosis code were included. Patients diagnosed with TIA and those admitted and discharged on the same day were excluded from the case ascertainment calculation. Case ascertainment for Emergency Department (ED) presentations recorded prior to hospital transfer was not undertaken.

Information on hospital admissions for stroke based on ICD-10 codes was gathered either from state government agencies, or from hospitals directly. In Victoria and Queensland, state government agencies facilitated data linkage with the government-held admitted episodes data-sets. Hospitals in other states were asked to provide a list of all admissions with stroke principal diagnosis ICD-10 codes from their hospital systems.

Hospital-reported admissions were compared and matched with episodes recorded in the AuSCR. Following matching, the hospitals were provided with a list of episodes, per period, that are not in the AuSCR to assist with improving overall ascertainment of cases.

The overall proportion of completeness for case ascertainment was estimated using the formula A/(A+B), where: 'A' was the number of eligible episodes that were registered in the AuSCR and 'B' was the number of episodes included in the hospital's list of eligible episodes that were missing from the AuSCR database.

Data quality reports

Data quality reports are used to provide hospitals with a list of AuSCR episodes containing missing data and/or data discrepancies (e.g. a discharge date prior to an admission date). These reports are designed to assist hospitals to identify and update individual AuSCR episodes, as required. The dissemination of these reports is bi-annual and provides hospitals with the opportunity to action any updates to their data prior to closure of a calendar year.

Data quality tables in dashboards

Five of the AuSCR QuickSight Dashboards, released between July 2023 and March 2024, include data quality tables listing records with missing or discrepant data (e.g. a negative door to brain scan time). The dashboards are updated at midnight each night so that any changes or additions made in AuSCR are reflected in the dashboards the following day. Hospital staff can login to the dashboards at any time to identify episodes that may require updating.

Medical record audits

The AuSCR office conducts medical record audits at participating hospitals to assess the accuracy of data in the registry compared to information documented in the hospital medical record. These audits assist in verifying that data quality for the AuSCR and information on areas to improve standardised collection of variables. The process is useful to support specific areas of data collection training that may

be required for staff at participating hospitals. Therefore, the audit process helps support improved standardised data collection for the registry. Medical record audits are scheduled to occur for a new participating hospital following entry of the first 50 episodes of stroke, on request or every two years, where feasible.

Routine data cleaning processes by AuSCR office

The overall assessment and cleaning of AuSCR data is completed fortnightly. Duplicate data are identified and removed by an AuSCR Data Manager using registrant identifiers (name, date of birth, Medicare number and/or hospital medical record number) in addition to date of stroke onset, date of hospital arrival and dates of admission and discharge. Episodes that appear ineligible or with incorrect dates of birth are flagged with hospitals for checking. Additional checks are undertaken following the closure of data entry for the year and prior to undertaking analysis for the AuSCR Annual Report. These data are subsequently de-identified and extracted for analysis. Additional data cleaning processes including logic checks for erroneous data are then undertaken by Monash University epidemiologists prior to undertaking data analyses, and additional feedback provided to hospitals, where required. The deidentified, final data for each year are then archived.

Time to record creation

The median time from admission to record creation in the AuSCR was 69 days (interquartile range: 46 to 104 days), 9 days faster than the median in 2023 of 78 days, and significantly improved from 92 days in 2022. More than half of AuSCR hospitals (n=42 hospitals; 61%) had a median time to record creation under 90 days, similar to 2023 (62% below 90 days). Overall, 1,153 episodes (5.8%) were entered over six months from admission and were ineligible to receive follow-up. The shortest hospital-level median time to record creation was one day, and the longest was 366 days.

Data completeness

For 2024, 69 hospitals provided data for 19,831episodes care. After excluding 12 episodes of TIA (50% male; median age 79 years), the final analysis sample was 19,819 episodes of stroke care in 2024 (19,182 admitted episodes and 637 emergency department [ED] episodes), provided by 69 hospitals. The proportion of data completeness for individual variables is presented only for eligible episodes, since not all variables are relevant to every patient.

Individual variables ranged in completeness from 25% for medical complication ICD-10 codes, which do not occur in every episode, to 100% for a range of variables, with similar overall results to the 2023 dataset (n=17,535 episodes from 63 hospitals, Table 1). Provision of the principal diagnosis ICD-10 code(s) improved to 88% in 2024 from 79% in 2023.

The only variable with greater than 5% reduced completion was specification of type of adverse event following thrombolysis (decreased from 94% in 2023 to 81%), noting this is only relevant to a small proportion of patients who had an adverse event following thrombolysis.

Completion of the National Institutes of Health Stroke Scale (NIHSS) which is invaluable for risk adjustment analysis was similar to 2023 (75% baseline score completed, Table 2).

Table 1: Completeness of variables in the Australian Stroke Clinical Registry, by year

Variable N=19,182 episodes in 2024	2023 % complete N hospitals=63	2024 % complete N hospitals=69
†Patient details		
Title	99	99
First name	100	100
Surname	100	100
Date of birth	100	100
Medicare number (optional, valid number)‡	**60**	**58**
Hospital Medical Record Number (MRN)	100	100
Gender	100	100
Country of birth	99	99
Language spoken	**88**	**87**
Interpreter needed	**89**	**89**
Aboriginal and Torres Strait Islander status	100	96
Patient phone number	95	96
Complete address (street address, suburb, state)	99	98
†Emergency contacts		
Emergency contact first name	**88**	**88**
Emergency contact last name	**87**	**87**
Address for emergency contact	**72**	**70**
Emergency contact phone number	**85**	**85**
Arrival and admission data		
Date of stroke onset	97	96
Time of stroke onset	**81**	**80**
Stroke occurred while in hospital	100	100
Date of arrival to ED	99	98
Time of arrival to ED	99	99
Arrival by ambulance	96	95
Transfer from another hospital	100	99
Date of admission	100	100
Time of admission	100	100
Treated in a stroke unit	100	100
History of known risk factors		
Documented evidence of a previous stroke	98	98
Acute clinical data		
Brain scan after this stroke	100	100
Date of first brain scan	99	98
Time of first brain scan	95	93
Date of subsequent brain scan	100	100
Time of subsequent brain scan	99	99
Type of stroke	100	100
Cause of stroke	100	99
Acute occlusion site	100	100
Telemedicine and reperfusion		
Stroke telemedicine consultation conducted	100	100
Receipt of thrombolysis	98	97
Date of delivery	100	100
Time of delivery	100	99
Adverse event related to thrombolysis	99	100
Type of adverse event	94	**81**
Other reperfusion (EVT)	100	100

Table 1: Completeness of variables in the Australian Stroke Clinical Registry, by year (continued)

Variable N=19,182 episodes in 2024	2023 % complete N hospitals=63	2024 % complete N hospitals=69
Treatment date for EVT)	100	100
Time groin puncture	100	99
Time of completing	100	98
Final eTICI	**81**	**82**
Haemorrhage within the infarct on follow up imaging	100	99
Details	**85**	**81**
Swallowing		
Swallowing screen	**90**	92
Date of swallowing screen	99	100
Time of swallow screen	96	96
Did the patient pass the screening	100	100
Swallowing assessment	**90**	92
Date of swallow assessment	100	100
Time of swallow assessment	98	97
Oral medications	**90**	92
Oral food or fluids	**90**	92
Mobilisation		
Ability to walk independently on admission	95	95
Mobilised during the admission	94	94
Date of mobilisation	100	100
Method of mobilisation	**90**	93
Antithrombotic therapy		
Antithrombotic given as hyperacute therapy	90	92
Date of administration	98	97
Time of administration	96	96
Secondary prevention		
Discharge antithrombotics	100	100
Discharge antihypertensives	99	100
Discharge lipid lowering	100	100
Discharge information		
Patient died during hospital stay	100	100
Date of death (for episodes deceased during hospital stay)	100	100
Date of discharge if not deceased while in hospital	99	99
Principal diagnosis ICD-10 code(s)	**79**	**88**
Medical condition ICD-10 code(s)*	**70**	**74**
Medical complication ICD-10 code(s)*	**25**	**25**
Medical procedure ICD-10 code(s)*	**70**	**71**
Discharge destination if not deceased while in hospital	100	100
Evidence of care plan on discharge if discharged to the community	97	98

Bold numbers indicate ›10% missing or discrepant data.
Includes data from paediatric hospitals.
† Excludes patients that have opted out their personal information
‡ 2023 and prior included significant proportion of "dummy" entries, e.g. 0000000
* Denominator includes some patients with no other medical condition, complication or procedure codes.
EVT: Endovascular therapy.
eTICI: Expanded Thrombolysis In Cerebral Infarction. ICD: International Classification of Diseases.

Table 2: Completeness of National Institutes of Health Stroke Scale Scores in the Australian Stroke Clinical Registry

Variable N=19,182 episodes in 2024	2023 % complete	2024 % complete
National Institutes of Health Stroke Scale (NIHSS)		
Baseline	**74**	**75**
Pre-EVT*	98	96
24 hours post-EVT	**78**	**77**

Bold numbers indicate ›10% missing or discrepant data.
*Note: where pre-EVT NIHSS was not captured, baseline NIHSS is used in this calculation.
NIHSS: National Institutes of Health Stroke Scale.
EVT: Endovascular therapy.

Emergency Department Dataset

The Emergency Department (ED) dataset is an optional program that went live on 1 July 2019. This dataset enables the collection of data for stroke who presented to an ED and prior to transfer to another hospital for ongoing acute stroke care. There were 44 hospitals that contributed 637 episodes of stroke during 2024 (25 in Victoria, 11 in QLD, 4 in WA, 3 in SA, and 1 in TAS), thirteen more than in 2023. The completeness of ED variables ranged from 87% (for NIHSS baseline) to 100% for a range of variables and was overall similar to 2023. Triage category improved from 85% in 2023 to 91% in 2024.

Emergency Department dataset variables were included in the data quality report provided to participating hospitals for the full 2024 year in May 2025.

Table 3: Completeness of Emergency Department dataset variables

Variable N=637 episodes in 2024	2023 % complete N hospitals=30	2024 % complete N hospitals=44
Stroke onset and arrival data		
Stroke onset date	99	99
Stroke onset time	92	94
Date of arrival to emergency department	100	99
Time of arrival to emergency department	100	99
Arrival by ambulance	100	100
Pre-hospital notification by paramedics	99	99
Acute clinical data		
Functional status prior to stroke (mRS)	98	99
Triage category	**85**	91
NIHSS at baseline	**84**	**87**
Brain scan after this stroke	100	100
Date of first brain scan	99	99
Time of first brain scan	97	98
Advanced imaging	100	100
Type of stroke	100	100
Telemedicine consultation	100	100
Receipt of thrombolysis	99	99
Date of delivery	100	100
Time of delivery	100	100
Drug used	100	100
Type of adverse event	100	100
Swallow screen	96	94
Was the swallow screen or swallow assessment performed before the patient was given:		
Oral medications	96	94
Oral food or fluids	96	94
Walk on admission	**85**	**90**
Transfer		
Date of transfer	99	98
Time of transfer	97	93
Reason for transfer	98	97
Discharge Information		
What is the discharge destination	98	97

Bold numbers indicate ›10% missing or discrepant data.
NIHSS: National Institutes of Health Stroke Scale.
mRS: Modified Rankin Scale.

Fever Sugar Swallow Dataset

The optional Fever Sugar Swallow (FeSS) dataset was made available on 1 July 2019. The FeSS dataset includes six variables in addition to the routinely collected swallow variables in the admitted patient datasets. Hospitals chose to complete these variables for all admitted episodes entered in the AuSCR, or for only a subset of the admitted cohort of patients. There were 26 hospitals that contributed to the FeSS dataset in 2024, two more than in 2023. A total of 6,993 FeSS episodes were recorded (Table 4) over 2,000 more than in 2023 and were generally well completed.

Table 4: Completeness of Fever, Sugar, Swallow dataset variables

Variable N= 6,993 episodes in 2024	2023 % complete N hospitals=24	2024 % complete N hospitals=26
Temperature recorded at least four times on day one of admission	94	92
Fever development in the first 72 hours following admission	100	100
Paracetamol for the first elevated temperature administered within 1 hour	100	100
Finger-prick blood glucose level recorded at least four times on day one of admission	94	92
Elevated glucose in the first 48 hours following admission	98	100
Insulin administered within 1 hour if elevated glucose	100	100

Data discrepancies identified using hospital medical record audit data

In 2024 the AuSCR conducted Medical Record Audits at five hospitals, three in Victoria and two in Queensland. Five to six records were reviewed per site with a total of 27 records reviewed. There were several variables where >10% discrepancy between the auditor and hospital medical records was found. These included patient mobile phone number (22% discrepancy, all from one hospital), time and accuracy of stroke onset (15% and 11% discrepancy respectively), treated in a stroke unit (11% from one hospital), baseline NIHSS (19%) and time of first brain scan (26%). There were fewer areas with discrepancies found in 2024 compared to 2023, however stroke onset and first brain scan remain areas with discrepancies, which can relate to having multiple times recorded in parts of the medical record for these variables.

CASE ASCERTAINMENT

For 2024 admissions, the AuSCR office conducted three rounds of case ascertainment reviews. The first two rounds provide feedback to hospitals on episodes potentially missing in the AuSCR, the third round is completed once the dataset is closed and hospitals have had the opportunity to enter any additional episodes and feedback on ineligible episodes to the AuSCR office. The first was for the period 1 January to 30 June 2024, the second and third included the full 2024 calendar year.

Episode matching for case ascertainment may be affected by data entry errors, in those variables used to match episodes between the datasets (e.g. patient names, hospital medical record number). However, following assessment of the resultant cases using automated and manual matching processes conducted by the AuSCR office, these matching errors made up a relatively small proportion of the overall total.

Of the 69 hospitals that contributed data in 2024, 65 (94%) provided data for case ascertainment, an improvement on previous years (92% in 2023, 89% in 2022). The median case ascertainment result was 86% in 2024, similar to 87% recorded in 2023. Some lower rates of case ascertainment were explained by hospitals not contributing for the full year.

Table 5: Hospital case ascertainment results for 2024 data and the 2023 dataset

Hospital ID	Episodes in the AuSCR 2024	Episodes in hospital records not in the AuSCR 2024	Case ascertainment 2024 N=69 hospitals	Case ascertainment 2023 N=63 hospitals
	n	n	%	%
1	489	-	Not provided^	Not provided
3	546	121	81%	78%
5	636	1	100%	100%
11	24	13	41%	47%
13	96	14	87%	100%
14	477	72	85%	90%
15	294	342	44%	86%
20	479	45	90%	93%
22	183	86	62%	16%*
23	151	6	95%	99%
24	743	139	82%	82%
26	191	70	68%	55%
27	323	18	94%	93%
29	161	19	87%	100%
30	112	97	48%	43%
31	384	60	85%	84%
32	153	78	64%	43%
33	127	64	65%	68%
34	242	0	100%	86%
35	270	3	99%	100%
36	253	40	86%	82%
37	346	1	100%	99%
38	247	69	76%	70%
39	224	0	100%	100%
40	618	6	99%	86%
41	151	4	97%	94%
42	28	13	68%	71%
43	150	16	89%	100%
44	148	114	53%	53%
45	176	13	94%	79%
46	1035	75	93%	83%
47	151	14	90%	95%
48	78	9	88%	86%
49	26	10	68%	80%
50	201	28	87%	88%
51	64	38	62%	29%*
52	425	36	91%	80%
53	431	93	80%	86%
55	10	0	100%^	Data pause
56	42	80	29%^	Data pause
57	247	45	78%	76%
58	1282	8	99%	100%
61	119	131	42%	Not provided
62	65	0	100%	100%
63	114	1	100%	100%
64	52	0	100%	100%
65	618	6	99%	76%
66	463	25	94%	87%

Table 5: Hospital case ascertainment results for 2024 data compared to the 2023 dataset (continued)

Hospital ID	Episodes in the AuSCR 2024 n	Episodes in hospital records not in the AuSCR 2024 n	Case ascertainment 2024 N=69 hospitals %	Case ascertainment 2023 N=63 hospitals %
67	32	0	100%	100%
68	77	0	100%	98%
69	1193	1	100%	99%
70	387	3	99%	99%
71	543	1	100%	100%
80	106	0	100%	91%
89	65	0	100%	100%
90	4	1	50%^	62%
91	455	-	Not provided	Not provided
92	166	60	70%	Not provided
93	136	2	98%	100%
94	763	17	98%	72%
95	199	106	39%	53%
96	260	44	86%	96%
97	302	0	100%	100%
108	3	-	Not provided	Not provided
113	51	-	Not provided^	Not provided
114	9#	41	0%^	Not provided
116	4	-	0%	Commenced 2024
117	7	1	88%	63%
118	4	3	25%	Commenced Aug 2024

**Hospital had data pause and did not collect data for the full 2023 year*
^Hospital had data pause or did not collect data for the full 2024 year
#Hospital submitted 9 records but none were matched possibly due to entry error

OPT-OUT REQUESTS AND REFUSAL TO COMPLETE FOLLOW-UP SURVEY

Since 2016, approval from National Human Research Ethics Committees (HREC) for the AuSCR to retain anonymous clinical data independently of personal data opt-outs has been in place. Though registrants are provided with the opportunity to opt-out both their personal and clinical data upon request.

A total of 331 opt-out requests (1.7% of all episodes) were received from patients or their nominated contact person for 2024 admissions (Table 6). These data are consistent with the opt-out rate recorded in 2023 of 1.8%. The request for removal of both clinical and personal data has remained very low each year, at less than 0.1%. The number of patients refusing follow-up participation prior to 90 days post-admission remained low at 1.2%.

Table 6: Opt-out requests and refusal to complete follow-up survey data

Year	Total episodes	Total opt-out episodes	Complete clinical and personal data to be removed	Personal data only to be removed	Refused to complete follow-up survey prior to 90 days
2023	18,662	339 (1.8%)	4 (<0.05%)	335 (1.8%)	176 (0.9%)
2024	19,182	331 (1.7%)	15 (0.08%)	316 (1.6%)	232 (1.2%)

Comparison of clinical stroke diagnosis and coded Principal Diagnosis

The AuSCR office reviews the clinician designated type of stroke within the registry against the ICD-10 discharge coding undertaken by hospital administrative staff. The ICD-10 discharge diagnosis code was compared to the documented clinical stroke type. Stroke diagnosis codes were either recorded as the principal diagnosis, or in the medical complication or medical condition fields available in the AuSCR dataset. Where more than one eligible stroke code was recorded for an individual episode, it was included in both clinical diagnosis categories.

For episodes recorded clinically as an ischaemic stroke, 75% of these episodes had an I63 discharge diagnosis code (ICD-10 codes for cerebral infarction: I63.0 to I63.9), and 4% were coded as I64 (stroke, not specified; Table 7). Seventy-seven percent of episodes recorded as an intracerebral haemorrhage by the clinician were coded as an intracerebral haemorrhage (ICH) code (ICD-10 code range: I61.0 to I61.9 and I62.9). Undetermined stroke type was recorded clinically in 1.0% of episodes, fewer than in 2022 (2.4%).

Table 7: Comparison of clinician assigned stroke diagnosis and the ICD-10 principal diagnosis codes

Principal, medical or complication code	Clinical diagnosis (N=19,116)		
	ICH N=2,890 (%)	Ischaemic N=16,038 (%)	Undetermined N=188 (%)
ICH ICD-10 codes (I61.x and I62.9)	**77%**	1%	1%
Ischaemic ICD-10 codes (I63.x)	2%	**75%**	50%
TIA ICD-10 code (G45.9)	<1%	<1%	1%
Unspecified stroke ICD-10 code (I64)	<1%	4%	**30%**
Multiple stroke/TIA ICD-10 codes	2%	4%	1%
Missing or non-stroke/TIA ICD-10 codes	18%	16%	17%

Bold numbers indicate a match between clinical diagnosis recorded by the clinician and ICD-10 codes.
Excludes ED episodes and 269 episodes with missing data for clinical diagnosis recorded by the clinician.
ICH: intracerebral haemorrhage; TIA: transient ischaemic attack.
Clinical diagnosis of TIA excluded from table.

Summary

The provision of data by hospitals into AuSCR for the 2024 cohort has maintained excellent data quality, with performance comparable to 2023 and notable improvements in timeliness of data entry. The median time for hospitals to create a record from admission was 69 days - nine days faster than in 2023 and the best result to date. Eighty percent of episodes were entered within 90 days. Entering data within 90 days ensures patients receive outcome surveys and episodes are included in quality checks, giving sites greater opportunity to correct errors. This improvement may reflect the availability of near real-time dashboards and quarterly World Stroke Organisation Award reviews, with data assessed just 17 days after each quarter's close.

The representativeness of the data in the AuSCR remained excellent with a median case ascertainment result of 86% across 94% of participating hospitals. The rate of patients wishing to opt-out of having their personal details stored in the registry remained low at 1.7%. Overall completeness of variables was high and similar to previous years. The proportion of clinically 'undetermined' stokes continued to decline, falling to 1% in 2024 (188 episodes) compared with 1.4% (248 episodes) in 2023.

Medical record audits were limited in 2024 due to resource constraints. However more site visits occurred in 2025, with a large number of audits possible and results to be shared in the next Annual Report. These audits provide valuable opportunities to address data collection challenges and reinforce understanding of AuSCR processes and variable definitions.

The AuSCR office continues to provide support to staff to maintain high-quality data. Eleven interactive data dashboards available to 180 hospitals users, with the ability to view data in near real-time (data updated at midnight daily) with various filters and data display options. Five dashboards include a data quality tab enabling sites to monitor and improve data accuracy continuously.

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