072: PERFORMANCE INDICATORS FOR ACUTE STROKE CARE

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Improving the quality of care for stroke patients is a national priority area for the health system in Australia. The National Stroke Unit Program's objective is to establish a cohesive policy that identifies key elements of clinical best practice that should be implemented across a diverse range of clinical settings, resulting in coordinated stroke services throughout Australia. The policy required the development of performance indicators that would complement the other initiatives of accreditation of stroke services, and a national stroke register to collect patient outcome data.

Objective:
To develop a core set of performance indicators for Australia's National Stroke Unit Program that can evaluate the quality of care provided by clinical services in the management of patients with an acute stroke.

Method:
National Stroke Research Institute undertook the task of identifying and detailing a core set of clinical performance indicators for acute stroke care only (rehabilitative, secondary prevention and community based care were excluded). This work built on our previous work 'Stroke Care Outcomes: Providing Effective Services' (SCOPES) research project that resulted in the identification of fifteen processes of care important for acute stroke care [Cadilhac 2002]. Another literature search was undertaken to identify any significant processes of care or performance indicators that may have developed since the completion of the SCOPES project. Eventually, sixteen processes of care were profiled as performance indicators in detail with descriptions of: definition of terms, rationale for use, validity of research evidence, data type and reliability of data gathering, applicability to patient types, clinical relevance to stroke care, current practice and future applications. The criteria for selecting the performance indicators included: (a) complements existing performance measures; (b) directly and specifically relevant to acute stroke care and reflects the different clinical stages of care; (c) representative of the concerns for each stakeholder; (d) possible to measure accurately in a clinical setting with potential for improvement; and (e) accommodates the diversity of health care organizations providing acute stroke care. All performance indicator were reviewed by patients/care-givers and a range of different health professionals before finalising a core set.

Results:
A core set of eight performance indicators were recommended for the National Stroke Unit Program. The final list of performance indicators included (1) Documentation of swallowing ability within 24 hours of arrival at hospital; (2) Brain imaging with CT or MRI Scan within 12 hours of arrival at hospital; (3) Allied health assessment within one day of admission; (4) A clinical care plan exists to avoid complications and promote urinary continence-[further field trial recommended]; (5) The multidisciplinary team meet with the patient and their carer within 7 days of admission [further field trial recommended]; (6) Appropriate discharge strategy: a timely and informative provision of a discharge summary and a self management (consumer) care plan; (7) Commencement of aspirin for patients with a thrombotic or thrombi-embolic stroke within 48 hours of admission; and(8) Commencement of an anti-platelet or anti-thrombotic agent for patients with a thrombotic or thrombo-embolic stroke at time of separation.

Conclusions:
The National Stroke Unit Program identified eight processes of care performance indicators (6 ready for implementation, 2 require field trial) to monitor the quality of stroke care throughout Australia that will complement other strategies for improving care.

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Cadilhac D, Ogden K, IBRAHIM JE, Davis S, Donnan G, on behalf of the SCOPES Investigators Development Of Processes Of Care Performance Indicators For Acute Stroke. International Society for Quality in Health Care's 19th Annual International Conference Paris 5th –8th November 2002

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