Project 640: Canadian Stroke Strategy Performance Improvement II

Participation

- Mandatory for Newfoundland and Labrador and Ontario.
- Optional for all other jurisdictions.

Stroke Special Projects overview

Stroke Special Projects enable the capture of key process and outcome information based on the Heart and Stroke Foundation (HSF) Canadian Stroke Best Practice Recommendations, and support stroke surveillance, quality improvement, benchmarking and Accreditation Canada's Stroke Distinction program.

Project 640 is a joint effort between HSF, CorHealth Ontario[i] and the Canadian Institute for Health Information (CIHI).

This project collects data on patients who have been diagnosed with an acute/current stroke and certain other conditions that — from an ICD-10-CA classification perspective — are not classified as a hemorrhagic, ischemic or unspecified stroke. The other conditions included in this project are transient ischemic attack (TIA), transient retinal artery occlusion, intracranial and intraspinal phlebitis and thrombophlebitis, nonpyogenic thrombosis of intracranial venous system and central retinal artery occlusion.

Note: For the purpose of completing Stroke Special Projects, the term "**applicable condition**" will be used throughout the documentation to refer to the ICD-10-CA codes/conditions included.

i. As of June 22, 2017, the Ontario Stroke Network (OSN) is CorHealth Ontario, an organization formed by the merger of the Cardiac Care Network of Ontario and the OSN, with an expanded mandate spanning cardiac, stroke and vascular services through the entire course of care. CorHealth Ontario provides a strategic understanding of the care needs of both patients and providers, as the basis for clinical quality improvement, provincial planning, resource allocation and performance measurement of quality and outcomes.

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Stroke Special Project series

- Special Project 340 Canadian Stroke Strategy Performance Improvement (DAD/NACRS)
- Special Project 440 Endovascular Thrombectomy (DAD)
- Special Project 640 Canadian Stroke Strategy Performance Improvement II (DAD/NACRS)
- Special Project 740 Alpha FIM® (DAD)

It is strongly recommended that all stroke projects be completed where applicable.

CIHI's role includes liaising/communicating with the project lead of the HSF's Quality of Stroke Care in Canada performance program and CorHealth Ontario. Please submit your questions via CIHI's eQuery tool:

- For abstracting questions, select "Inpatient/ambulatory abstracting and education (DAD and NACRS)."
- For coding questions, select "Classifications Coding."

Project data

Project 640: Canadian Stroke Strategy Performance Improvement II

Field name	Field number	Valid data/format
Project Number	99	640
Dysphagia Screening	01	Y, N or 8 (Not applicable)
Telestroke Consultation	02	Y, N or 8 (Not applicable)
Date of Stroke Unit Admission	03–06	MMDD, 9999 (Unknown) or 8888 (Not applicable)
Date of Stroke Unit Discharge	07–10	MMDD, 9999 (Unknown) or 8888 (Not applicable)
Triage Date and Time	11–20	YYMMDDHHMM, 9999999999 (Unknown) or blank

Project completion guidelines

The inclusion and exclusion criteria for Special Project 640 are the same as those for Special Project 340. See Special Project 340 documentation for detailed completion guidelines.

Project 640 (Field 01): Dysphagia Screening

Specifications	
Field status	Mandatory if Project 640 is recorded
Field length	One (1) character
Valid data	Y, N or 8 (Not applicable)

Definition

This field indicates whether a patient with an "**applicable condition**" was screened for difficulty swallowing.

Dysphagia screening or swallowing screening includes a formal standardized swallowing screen test and/or informal bedside screening (such as taking a sip of water) made by appropriate health professionals, typically a speech–language pathologist, dietitian or nurse.

The purpose of the screening is to detect the presence or absence of dysphagia and thus determine the need for an in-depth assessment of dysphagia by a speech–language pathologist, occupational therapist, dietitian or other trained dysphagia clinician.

Typically, dysphagia screening is completed as early as possible as part of the initial assessment. It may have been performed while the patient was in the emergency department (ED) or after the patient was admitted to the acute care reporting facility.

Valid data legend

Code	Description
Y	**Yes** There is documentation that the patient was screened for dysphagia.
N	**No** There is no documentation that the patient was screened for dysphagia.
8	**Not applicable** The patient was unconscious, on a ventilator or otherwise incapacitated and dysphagia screening could not be performed.

Collection instructions

- Dysphagia screening or swallowing screening should be documented in the ED physician notes, admission history, history and physical, progress notes, consultant's notes, swallowing/dysphagia screening form, nurse's notes, physician notes and/or allied health notes in the ED or on admission to the facility.
- For a list of swallow screening tools, refer to *Canadian Stroke Best Practice Recommendations Swallow Screening and Assessment Tools*.

Project 640 (Field 02): Telestroke Consultation

Specifications	
Field status	Mandatory if Project 640 is recorded
Field length	One (1) character
Valid data	Y, N or 8 (Not applicable)

Definition

This field records whether a patient with an "**applicable condition**" used telestroke services.

HSF defines telestroke as the use of telecommunication technology to link referring and consulting health care sites together for real-time assessment and management of stroke patients. Presently, it is used primarily to extend access to thrombolytic treatment in health care facilities that do not have 24/7 on-site stroke expertise.[ii]

The patient is physically located at the referring site, while the physician stroke care expert is situated at the consulting site. Two-way audio–visual communication allows the consulting stroke expert to assess the patient as well as view CT images.

Valid data legend

Code	Description
Y	**Yes** There is documentation that the patient had telestroke consultation.
N	**No** There is no documentation that the patient had telestroke consultation.
8	**Not applicable** The facility does not have telestroke services/capacity.

ii. Heart and Stroke Foundation. *Telestroke Implementation Toolkit*. 2013.

Collection instructions

- Each facility's health record/health information management department should establish whether the facility participates in telestroke. The facility's ED manager should be able to confirm.
- Telestroke consultation should be documented on the ED physician notes, admission history, history and physical, progress notes, consultant's notes, nurse's notes, physician notes and/or in the ED/admission telestroke consultation form.
- Telestroke consultation does not include telephone referrals with no evidence of coordination through a telestroke program or consultations done within the reporting facility by a staff physician stroke care expert.

Project 640 (Fields 03–06): Date of Stroke Unit Admission

Specifications	
Field status	Mandatory if Project 640 is recorded
Field length	Four (4) characters
Valid data	MMDD, 9999 (Unknown) or 8888 (Not applicable)

Definition

These fields capture the date that a patient with an "**applicable condition**" was admitted to a designated stroke unit.

Refer to the Discharge Abstract Database (DAD) Special Project 340 Field 02 Admission to a Stroke Unit for definition of stroke unit.

Collection instructions

- When Admission to a Stroke Unit (DAD Project 340 Field 02) is recorded as Y (Yes),
  - Record the month and day when the patient was admitted to the designated stroke unit.

    Fields 03–04: Month (MM)

    Fields 05–06: Day (DD)
  - Record 9999 (Unknown) when date of stroke unit admission is unknown.
- When Admission to a Stroke Unit (DAD Project 340 Field 02) is recorded as N (No) or 8 (Not applicable),
  - Record 8888 (Not applicable).
- When the patient is admitted to the designated stroke unit multiple times during an acute care encounter, record the admission date of the first episode in the designated stroke unit. This will support identification of patients admitted to the designated stroke unit within 24 hours of ED triage.

Provincial/territorial variations

Ontario

Refer to DAD Special Project 340 Field 02 for CorHealth Ontario's stroke unit definition.

Project 640 (Fields 07–10): Date of Stroke Unit Discharge

Specifications	
Field status	Mandatory if Project 640 is recorded
Field length	Four (4) characters
Valid data	MMDD, 9999 (Unknown) or 8888 (Not applicable)

Definition

These fields capture the date that a patient with an "**applicable condition**" was discharged from a designated stroke unit.

Refer to DAD Special Project 340 Field 02 Admission to a Stroke Unit for definition of stroke unit.

Collection instructions

- When Admission to a Stroke Unit (DAD Project 340 Field 02) is recorded as Y (Yes),
  - Record the month and day when the patient was discharge from the designated stroke unit.

    Fields 07–08: Month (MM)

    Fields 09–10: Day (DD)
  - Record 9999 (Unknown) when date of stroke unit discharge is unknown.
- When Admission to a Stroke Unit (DAD Project 340 Field 02) is recorded as N (No) or 8 (Not applicable),
  - Record 8888 (Not applicable).
- When the patient is admitted to the designated stroke unit multiple times during an acute care encounter, record the discharge date of the first episode in the designated stroke unit.

Provincial/territorial variations

Ontario

Refer to DAD Special Project 340 Field 02 for CorHealth Ontario's stroke unit definition.

Project 640 (Fields 11–20): Triage Date and Time

Specifications	
Field status	Mandatory if Project 640 is recorded and the "**applicable condition**" occurred prior to ED arrival and Entry Code (Group 04 Field 06) is E (emergency)
Field length	Ten (10) characters
Valid data	YYMMDDHHMM, 9999999999 (Unknown) or blank

Definition

These fields identify the date and time when a patient with an "**applicable condition**" (that occurred prior to ED arrival) was triaged in the ED of the reporting facility.

Collection instructions

- Triage date and time should be available on the ED admission record, triage nurse assessment or other ED notes.
- These fields are optional to complete when Entry Code (Group 04 Field 06) is E (Emergency) and the reporting facility submits Level 3 ED data to the National Ambulatory Care Reporting System (NACRS).
- These fields must be blank when Entry Code (Group 04 Field 06) is a value other than E (Emergency) or when the "**applicable condition**" occurred after ED arrival.
- Record the year (last 2 digits), month, day, hour and minutes when the patient was triaged in the ED of the reporting facility.
  - Fields 11–12: Year (YY)
  - Fields 13–14: Month (MM)
  - Fields 15–16: Day (DD)
  - Fields 17–20: Hour (HH) and Minutes (MM)
- Record the time using the 24-hour clock. If your ADT system uses a 12-hour clock, record the hour converted per the 24-hour clock (00:00 to 23:59 hours).
- Record 9999999999 (Unknown) when the triage date and time are unavailable. However, if the date is known (e.g., April 1, 2018) but the time is not known, record what is available (e.g., 1804019999).