Appendix 1: CareTrack Australia - clinical indicators used to assess compliance for 22 conditions

Table 1 outlines the 22 conditions and the abbreviations that are used in the second column of Table 2.

Table 2 outlines the 522 CareTrack indicators used by condition, with their source, number of reviewers, mean score for appropriateness, level of evidence, and whether they were measured for under- or over-use.

Table 1: CareTrack conditions and abbreviations

Condition	Abbreviation
Antibiotic Use	AB
Preventive Care	PC
Surgical Site Infection	SSI
Venous Thromboembolism	VTE
Alcohol Dependence	AD
Asthma	A
Atrial Fibrillation	AF
Cerebrovascular Accident	CVA
Community Acquired Pneumonia	CAP
Chronic Obstructive Pulmonary Disease	COPD
Chronic Heart Failure	CHF
Coronary Artery Disease	CAD
Depression	DE
Diabetes	DI
Dyspepsia	DY
Hypertension	HYT
Hyperlipidaemia	HYL
Low Back Pain	LBP
Obesity	OB
Osteoarthritis	OA
Osteoporosis	OP
Panic Disorder	PD

Table 2: CareTrack Indicators by condition, source, reviewer numbers, mean reviewer scores (/9), level of evidence, and whether they are underuse or overuse indicators.

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
1	AB[$]	Patients presenting with pharyngitis were NOT prescribed antibiotics.	[1]	1	7	Consensus-based recommendations	O
2	AB[$]	Patients presenting with tonsillitis were NOT prescribed antibiotics.	[1]	1	7	Consensus-based recommendations	O
3	AB[$]	Patients presenting with non-suppurative otitis media were NOT prescribed antibiotics.	[1]	1	3	Consensus-based recommendations	O
4	AB[$]	Patients presenting with sinusitis (unless severe) were NOT prescribed antibiotics.	[1]	1	5	Consensus-based recommendations	O
5	AB[$]	Patients with severe sinusitis that present with at least three of the following symptoms were prescribed antibiotics: • Persistent muco-purulent discharge (>7 days); • Facial pain; • Poor response to decongestants; • Tender sinuses; • Tenderness on percussion of maxillary molar or pre molar teeth.	[1]	1	7	Consensus-based recommendations	U
6	PC	Patients are asked about the quantity and frequency of alcohol intake at least once in 2 years.	[2]	O[#]	O[#]	Consensus-based recommendations	U
7	PC	Females who are aged between 50-69 years have had screening mammography performed at least once in the two years.	[3, 4]	O[#]	O[#]	Grade A	U
8	PC	Patients who are aged > 50 have had screening arranged for colorectal cancer with a faecal occult blood test at least once in two years.	[5]	3	9	Level I Grade A	U
9	PC	Patients with a positive faecal occult blood test have been referred to a specialist.	[5]	3	9	Consensus-based recommendations	U
10	PC	Patients who are a category 1 risk (see definition) for colorectal cancer have had a faecal occult blood test at least once in two years.	[5]	3	8	Level I Grade A	U
11	PC	Patients who are aged > 50 years and are a category 1 risk (see definition) for colorectal cancer have had a colonoscopy at least once in 2 years.	[5]	3	6	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
12	PC	Patients who are a category 2 risk (see definition) for colorectal cancer have had one of the following at least once in the 2 years starting at age 50, or at an age 10 years younger than the first diagnosis of bowel cancer in the family: • Colonoscopy (sigmoidoscopy plus double contrast barium enema); • Computerised tomography (CT) colonoscopy (if colonoscopy not available).	[5]	3	8	Level III-2	U
13	PC	Patients with high-risk familial colorectal cancer syndrome (category 3 – see definition) have received counselling.	[5]	3	6	Consensus-based recommendations	U
14	PC	Patients with high-risk familial colorectal cancer syndrome have been referred to a cancer genetics specialist or family cancer specialist.	[5]	3	8	Level III-2	U
15	PC	Patients with high-risk familial colorectal cancer syndrome have had genetic testing performed.	[5]	3	6	Level III-2	U
16	PC	Females who are aged between 18-70years have had a pap smear performed at least once in the past two years.	[3]	O[#]	O[#]	Grade A	U
17	PC	Males who are aged between 50-75 years have documented evidence of a discussion regarding prostate screening.	[3]	O[#]	O[#]	Level V Grade C	U
18	PC	Males who are aged between 50 - 75 years that had prostate cancer screening had both prostate specific antigen and digital rectal examination performed.	[3]	O[#]	O[#]	Not recommended	O
19	PC	Patients aged >18yrs had their blood pressure (BP) measured at least once.	[6]	O[#]	O[#]	Grade A	U
20	PC	Patients aged >18yrs, with Systolic BP (SBP)<120 and Diastolic BP (DBP)<80 had their BP checked at least once in 2 years (unless Aboriginal & Torres Strait Islander (ATSI) then >15yrs).	[6]	4	7	Level I Grade A	U
21	PC	Patients aged >18yrs, with SBP 120-139 and DBP 80-89 has had their BP checked every year (unless ATSI then >15yrs).	[6]	4	7	Consensus-based recommendations	U
22	PC	Patients aged >18yrs with SBP140-159 and DBP 90-99 has had their BP rechecked within 2months (unless ATSI then >15yrs).	[6]	4	6	Consensus-based recommendations	U
23	PC	Patients aged >18yrs with SBP 160 - 179 and DBP 100 - 109, are reassessed or referred to a specialist within one month (unless ATSI then >15yrs).	[6]	4	6	Consensus-based recommendations	U
24	PC	Patients aged >18yrs with SBP >=180, DBP >=110 are reassessed or referred to a specialist within 7 days (unless ATSI then >15yrs).	[6]	O[#]	O[#]	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
25	PC	Patients aged >18yrs with isolated systolic hypertension SBP >=160, DBP <= 70 with widened pulse pressure had their BP reassessed or referred to a specialist within 7 days (unless ATSI then >15yrs).	[6]	O[#]	O[#]	Consensus-based recommendations	U
26	PC	Patients with elevated BP readings (mean > 140/90) on at least three separate occasions were diagnosed with hypertension.	[6]	O[#]	O[#]	Consensus-based recommendations	U
27	PC	Patients who are aged >45yrs have had fasting blood lipids checked once in the last two years.	[7]	O[#]	O[#]	Level IV	U
28	PC	Patients who are aged > 45 years (ATSI > 35 years) that smoke, have a history of hypertension and a familial history of premature cardiovascular disease have had fasting blood lipids performed at least once in two years.	[7]	O[#]	O[#]	Level IV	U
29	PC	Patients who are aged > 45 years (ATSI > 35 years) have had fasting blood lipids performed every year if they have two or more of the following conditions: • Diabetes; • Cardiovascular disease; • Chronic kidney disease; • Familial history of hyperlipidaemia; • Current smoker.	[7]	O[#]	O[#]	Level IV	U
30	PC	Patients aged >40 years (ATSI >18 years) have been assessed for diabetes at least once using Australian Type 2 Diabetes Risk Assessment Tool (AUSDRISK).	[3]	3	A[¥]	Level III Grade B	U
31	PC	Patients with any of the following conditions have had measurement of fasting plasma glucose every year: • Impaired glucose tolerance or fasting glucose >5.6mmol/L; • Females with a history of gestational diabetes; • Polycystic ovary syndrome; • People with a history of CAD; • People on antipsychotic medication.	[8]	3	6	Level III Grade B	U
32	PC	Patients screened for diabetes with equivocal results (Fasting Plasma Glucose (FPG) of 5.6-6.9 mmol/L or random plasma glucose of 5.5 - 11.0 mmol/L) at any time during the two year period had an oral glucose tolerance test performed.	[8]	3	5	Grade B	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
33	PC	Females, aged >= 45yrs with at least one of the following were assessed for osteoporosis each year: • Previous low trauma fracture; • Osteopenia /vertebral deformity; • A reduction in height (>0.5cm every year); • Thoracic kyphosis; • Premature menopause; • Family history of hip fracture; • Low body weight (Body Mass Index (BMI)<20); • Caffeine intake is considered high; • Glucocorticoid therapy >3mths (current or previous) • Eating disorder associated with low weight • Chronic liver disease; • Chronic kidney disease; • Malabsorption syndrome; • Amenorrhea > 6mths (before age 45); • Rheumatoid arthritis; • Over active thyroid; • Lifestyle of poor diet or limited sun exposure; • Risk of falls.	[3]	4	6	Level I Grade A	U
34	PC	Males, aged >50 with any of the following (hypogonadism, glucocorticoid use, excess alcohol, multiple myeloma or hyperthyroid) had an assessment of osteoporosis performed every year.	[3]	4	6	Level V Grade C	U
35	PC	Patients, aged >45 that have sustained a low trauma fracture have had a bone densitometry scan performed at least once.	[3]	4	8	Level II Grade B	U
36	PC	Post menopausal females with a suspected vertebral fracture or major risk factors have had a bone densitometry scan performed at least once.	[3]	4	8	Level II Grade B	U
37	SSI	Patients who require surgery involving the placement of a prosthesis received a prophylactic antibiotic.	[9]	4	8	Consensus-based recommendations	U
38	SSI	Patients who have clean-contaminated surgery received a prophylactic antibiotic.	[9]	4	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
39	SSI	Patients who have contaminated surgery received a prophylactic antibiotic.	[9]	4	8	Consensus-based recommendations	U
40	SSI	Patients who have clean non-prosthetic uncomplicated surgery DID NOT receive a prophylactic antibiotic.	[9]	4	8	Consensus-based recommendations	O
41	SSI	Patients that received prophylactic antibiotics had them administered 30-60 minutes prior to surgery.	[9]	4	7	Consensus-based recommendations	U
42	VTE	Patients admitted to hospital were risk assessed for VTE.	[10, 11]	3	8	Consensus-based recommendations	U
43	VTE	Patients who are discharged on anticoagulant therapy have a documented care plan that includes details on the intended duration of treatment.	[10, 11]	3	8	Consensus-based recommendations	U
44	VTE	Patients who are discharged on anticoagulant therapy have a documented care plan that includes a review date.	[10, 11]	3	8	Consensus-based recommendations	U
45	VTE	Patients who had a hip arthroplasty have received one of the following anticoagulant therapies for up to 35 days: • Enoxaparin 40mg/day; • Dalteparin 5000u/day; • Low Dose Unfractionated Heparin (LDUH) 5000u TDS; • Fondiparinux 2.5mg/day [commenced 6 - 8 hours post op]; • Rivaroxaban[Oral]; • Dabigatran [Oral].	[10, 11]	3	7	Grade A (Enoxaparin and Dalteparin) Grade B (Fondiparinux, Rivaroxaban and Dabigatran)	U
46	VTE	Patients who hip fracture surgery have received one of the following anticoagulant therapies for up to 35 days: • Enoxaparin 40mg/day; • Dalteparin 5000u/day; • LDUH 5000u TDS; • Fondiparinux 2.5mg/day [commenced 6 - 8 hours post op].	[10, 11]	3	7	Grade B	U
47	VTE	Patients who had a knee arthroplasty have received one of the following anticoagulant therapies for up to 28 days: • Enoxaparin 40mg/day; • Dalteparin 5000u/day; • LDUH 5000u TDS; • Fondiparinux 2.5mg/day [commenced 6 - 8 hours post op];	[10, 11]	3	6	Grade A (Enoxaparin and Dalteparin) Grade B (Fondiparinux, Rivaroxaban and	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
		• Rivaroxaban [Oral]; • Dabigatran [Oral].				Dabigatran)	
48	VTE	Patients who had a lower limb fracture received one of the following anticoagulant therapies for at least 5 days or until fully mobile: • Enoxaparin 40mg/day; • Dalteparin 5000u/day; • LDUH 5000u TDS; • Fondiparinux 2.5mg/day (commenced 6 - 8 hours post op).	[10, 11]	3	6	Grade A	U
49	VTE	Patients who had a general surgical procedure received one of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile: • Enoxaparin 20mg/day; • Dalteparin 2500U/day.	[10, 11]	3	6	Grade B	U
50	VTE	Patients who had gynaecological surgery received one of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile: • Enoxaparin 20mg/day; • Dalteparin 2500U/day.	[10, 11]	3	6	Grade B	U
51	VTE	Patients who had abdominal surgery received one of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile: • Enoxaparin 20mg/day; • Dalteparin 2500U/day.	[10, 11]	3	6	Grade B	U
52	VTE	Patients who had cardiac, thoracic or vascular surgery received one of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile: • Enoxaparin 20mg/day; • Dalteparin 2500U/day.	[10, 11]	3	6	Grade B	U
53	VTE	Patients who had trauma or spinal surgery received one of the following anticoagulant therapies commenced after primary haemostasis was established (unless contraindicated) until hospital discharge or fully mobile: • Enoxaparin 20mg/day; • Dalteparin 2500U/day.	[10, 11]	3	A[¥]	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
54	VTE	Patients who have cancer that underwent surgery received one of the following anticoagulant therapies (unless contraindicated) until hospital discharge or fully mobile: • Enoxaparin 20mg/day; • Dalteparin 2500U/day.	[10, 11]	3	A[¥]	Consensus-based recommendations	U
55	VTE	Medical patients admitted to hospital with ischemic stroke received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day; • LDUH 5000U BD or TDS.	[10, 11]	3	7	Grade B	U
56	VTE	Medical patients admitted to hospital with myocardial infarct (where full anticoagulant is not in use) received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day; • LDUH 5000U BD or TDS.	[10, 11]	3	A[¥]	Grade C	U
57	VTE	General Medical patients admitted to hospital assessed as being at risk of VTE following risk assessment received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day; • LDUH 5000U BD or TDS.	[10, 11]	3	6	Grade B	U
58	VTE	Medical patients admitted to hospital with active cancer received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day; • LDUH 5000U BD or TDS.	[10, 11]	3	7	Consensus-based recommendations	U
59	VTE	Medical patients admitted to hospital with decompensated cardiac failure received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day;	[10, 11]	3	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
		• LDUH 5000U BD or TDS.					
60	VTE	Medical patients admitted to hospital with acute on chronic lung disease received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day; • LDUH 5000U BD or TDS.	[10, 11]	3	7	Consensus-based recommendations	U
61	VTE	Medical patients admitted to hospital with acute on chronic inflammatory disease received one of the following anticoagulant therapies until resolution of the acute medical illness or until hospital discharge: • Enoxaparin 40mg/day; • Dalteparin 5000U/day; • LDUH 5000U BD or TDS.	[10, 11]	3	7	Consensus-based recommendations	U
62	VTE	Patients having a Total Hip Replacement have been prescribed graduation compression stockings.	[10, 11]	3	6	Grade B	U
63	VTE	Patients having general surgery have been prescribed graduation compression stockings.	[10, 11]	3	6	Grade B	U
64	VTE	Patients having gynaecological surgery have been prescribed graduation compression stockings.	[10, 11]	3	6	Consensus-based recommendations	U
65	VTE	Patients having abdominal surgery have been prescribed graduation compression stockings.	[10, 11]	3	6	Grade B	U
66	VTE	Patients having cardiac, thoracic or vascular surgery have been prescribed graduation compression stockings.	[10, 11]	3	A$^¥$	Grade C	U
67	VTE	Patients having neurosurgery have been prescribed graduation compression stockings.	[10, 11]	3	A$^¥$	Grade C	U
68	VTE	Patients having a total hip replacement have been prescribed an intermittent pneumatic compression device.	[10, 11]	3	6	Grade B	U
69	VTE	Patients having hip fracture surgery have been prescribed an intermittent pneumatic compression device.	[10, 11]	3	6	Grade C	U
70	VTE	Patients having a total knee replacement have been prescribed an intermittent pneumatic compression device.	[10, 11]	3	6	Grade C	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
71	VTE	Patients having cardiac, thoracic or vascular surgery have been prescribed an intermittent pneumatic compression device.	[10, 11]	3	A[¥]	Grade C	U
72	VTE	Patients having neurosurgery have been prescribed an intermittent pneumatic compression devices.	[10, 11]	3	A[¥]	Grade A	U
73	VTE	Patients having a total hip replacement have been prescribed a foot pump.	[11]	3	A[¥]	Grade B	U
74	VTE	Patients having a total knee replacement have been prescribed a foot pump.	[11]	3	A[¥]	Grade C	U
75	VTE	Patients having hip fracture surgery have been prescribed a foot pump.	[11]	3	A[¥]	Grade C	U
76	VTE	Patients with a suspected Deep Vein Thrombosis (DVT) had a venous duplex ultrasound performed.	[10]	3	8	Consensus-based recommendations	U
77	VTE	Patients with a suspected PE had one of the following investigations performed: • Ventilation perfusion scan; • CT angiography; • Pulmonary angiography.	[10]	3	6	Consensus-based recommendations	U
78	VTE	Patients with a suspected DVT or Pulmonary Embolus (PE) where ultrasound was delayed, anticoagulant therapy was commenced (unless contraindicated) as soon as clinically suspected	[10]	3	9	Consensus-based recommendations	U
79	VTE	Patients with a confirmed DVT / PE received one of the following anticoagulant therapies: • Heparin administered together with warfarin for at least 5 days; • Unfractionated heparin IV (Activated Partial Thromboplastin Time (APTT)) or subcutaneous (dose/kg); • Low Molecular Weight Heparin (LMWH) subcutaneously at least once daily.	[10]	3	A[¥]	Consensus-based recommendations	U
80	VTE	Patients who were administered heparin therapy had it continued until the International Normalized Ratio (INR) had been therapeutic for 48 hours (INR range 2.0 - 3.0).	[10]	3	A[¥]	Consensus-based recommendations	U
81	AD	Patients admitted to hospital with trauma have had their alcohol intake documented at least once.	[2]	3	8	Consensus-based recommendations	U
82	AD	Patients admitted to hospital with hepatitis have had their alcohol intake documented at least once.	[2]	3	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
83	AD	Patients admitted to hospital with pancreatitis have had their alcohol intake documented at least once.	[2]	3	A[¥]	Consensus-based recommendations	U
84	AD	Patients admitted to hospital with depression have had their alcohol intake documented at least once.	[2]	3	A[¥]	Consensus-based recommendations	U
85	AD	Patients admitted to hospital with suicidal ideation and/or suicidal attempt have had their alcohol intake documented at least once.	[2]	3	A[¥]	Consensus-based recommendations	U
86	AD	Patients admitted to hospital who are aggressive or violent have had their alcohol intake documented at least once.	[2]	3	A[¥]	Consensus-based recommendations	U
87	AD	Patients hospitalised and identified as having a drinking problem have been further assessed using the Alcohol Use Disorders Identification Test (AUDIT) tool.	[2]	3	A[¥]	Consensus-based recommendations	U
88	AD	Patients hospitalised and identified as having a drinking problem were referred to a mental health or addiction medicine specialist.	[2]	3	A[¥]	Consensus-based recommendations	U
89	AD	Patients hospitalised and identified as having a drinking problem were observed using an alcohol withdrawal chart.	[2]	3	A[¥]	Consensus-based recommendations	U
90	AD	Alcohol intake assessment includes documentation of dependence (tolerance of psychoactive effects, loss of control, interference with daily tasks).	[2]	3	9	Consensus-based recommendations	U
91	AD	Alcohol intake assessment includes documentation of its consequences of use.	[2]	3	9	Consensus-based recommendations	U
92	AD	Alcohol intake assessment includes documentation of the patient's behaviour (Argumentative, aggressive or violent).	[2]	3	7	Consensus-based recommendations	U
93	AD	Patients diagnosed with alcohol dependence have been offered one of the following: • Inpatient rehabilitation program; • Outpatient rehabilitation program; • Mutual help group (e.g. Alcoholics anonymous); • Substance abuse counselling; • Aversion therapy; • Anti-craving medication (disulfiram, naltrexone, acamprostate, baclofen).	[2]	3	7	Consensus-based recommendations	U
94	A	Patients with moderate to severe asthma (see definition) had an evaluation of precipitating factors documented (allergens, family history, diet, smoking, infection) within 6 months of diagnosis.	[2]	3	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
95	A	Patients with moderate to severe asthma (see definition) had baseline spirometry or peak flow performed within 6 months of diagnosis.	[2]	3	9	Consensus-based recommendations	U
96	A	Patients with moderate to severe asthma (see definition) were prescribed a beta 2 agonist inhaler within 6 months of diagnosis.	[2]	3	8	Consensus-based recommendations	U
97	A	Patients with moderate to severe asthma (see definition) prescribed beta blocker medication had it ceased within 6 months of diagnosis.	[2]	3	8	Consensus-based recommendations	U
98	A	Patients with moderate to severe asthma (see definition) were given a flu vaccination within 6 months of diagnosis.	[2]	3	7	Consensus-based recommendations	U
99	A	Patients with symptomatic asthma were prescribed reliever therapy (salbutamol, atrovent, bricanyl, flixotide) at time of presentation.	[12]	3	9	Level I	U
100	A	Patients that reported asthma symptoms more than 3 times per week were prescribed preventer medication (Seretide, Symbicort, Flixotide).	[12]	3	9	Level I	U
101	A	Patients with asthma that report using short acting beta2 agonists (SABA) more than 3 times per week were prescribed preventer medication.	[12]	3	9	Level I	U
102	A	Patients treated with preventer (Seretide, Symbicort, Flixotide) medication were prescribed low dose inhaled corticosteroids.	[12]	3	7	Level I	U
103	A	Patients who presented to an emergency room or to their General Practitioner (GP) with an exacerbation of asthma had current medications documented at presentation.	[2, 12]	3	8	Consensus-based recommendations	U
104	A	Patients who presented to an emergency room or to their GP with an exacerbation of asthma had previous hospital admissions, Emergency Department (ED) presentations or respiratory complications documented.	[2, 12]	3	9	Consensus-based recommendations	U
105	A	Patients who presented to an emergency room or to their GP with an exacerbation of asthma had lung function assessed using Peak Expiratory Flow Rate (PEFR)/peak flow or Forced Expiratory Volume in 1 Second (FEV1).	[2, 12]	3	8	Consensus-based recommendations	U
106	A	Patients who presented to an emergency room or to their GP with an exacerbation of asthma and a PEFR/peak flow or FEV1 less than 70% of baseline were prescribed an inhaled corticosteroid.	[2, 12]	3	7	Consensus-based recommendations	U
107	A	Patients who presented to an emergency room or to their GP with an exacerbation of asthma, that were currently prescribed theophylline had a theophylline level performed.	[2, 12]	3	6	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
108	A	Patients who presented to an emergency room or to their GP with an exacerbation of asthma had a chest examination performed.	[2, 12]	3	9	Consensus-based recommendations	U
109	A	Patients who presented to an emergency room or to their GP with an exacerbation of asthma had their oxygen saturation measured and maintained > 90% for the duration of the visit.	[2, 12]	3	9	Consensus-based recommendations	U
110	A	Patients hospitalised with asthma have had their oxygen saturation measured.	[2, 12]	3	9	Consensus-based recommendations	U
111	A	Patients hospitalised with asthma were prescribed systemic steroids (Per Oral (PO) or intravenous (IV)).	[2, 12]	3	9	Level I	U
112	A	Patients hospitalised with asthma were prescribed a beta2 agonist.	[2, 12]	3	9	Consensus-based recommendations	U
113	A	Patients hospitalised with asthma were advised to see their GP within 14 days of discharge.	[2, 12]	3	7	Consensus-based recommendations	U
114	A	Patients hospitalised with asthma that were not ventilated or not physiologically dependent on sedative medications or currently withdrawing from alcohol were prescribed sedative medication.	[2, 12]	3	8	Consensus-based recommendations	U
115	A	Patients hospitalised with asthma with oxygen saturation < 90% (unless PCO2 > 40 previously documented) were prescribed oxygen therapy.	[2, 12]	3	9	Consensus-based recommendations	U
116	A	Patients hospitalised with asthma without a previously recorded PCO2 > 40, had at least one additional blood gas performed during the admission.	[2, 12]	3	7	Consensus-based recommendations	U
117	A	Patients newly prescribed inhaled bronchodilators were given a spacer device and instructed on its use.	[2]	3	8	Level II	U
118	A	Patients with a diagnosis of asthma have a documented asthma action plan in their medical record.	[12]	3	7	Level I	U
119	A	Patients with asthma have had their smoking status monitored at each visit.	[12]	3	8	Consensus-based recommendations	U
120	A	Patients with asthma have had their inhaler technique checked at each visit.	[12]	3	6	Level II	U
121	A	Patient prescribed inhaled corticosteroids were considered for a reduction in maintenance.	[12]	3	7	Consensus-based recommendations	U
122	AF	Patients with new onset AF or AF of unknown duration have had alcohol intake documented at presentation.	[2]	5	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
123	AF	Patients with new onset AF or AF of unknown duration have had stimulant drug use documented at presentation.	[2]	5	7	Consensus-based recommendations	U
124	AF	Patients with new onset AF or AF of unknown duration have had thyroid function checked within 2 weeks (unless checked previously) at presentation.	[2]	5	8	Consensus-based recommendations	U
125	AF	Patients with AF were NOT prescribed warfarin if there was evidence of active bleeding.	[2]	5	9	Consensus-based recommendations	O
126	AF	Patients with AF were NOT prescribed warfarin if they have a history of haemophilia.	[2]	5	8	Consensus-based recommendations	O
127	AF	Patients with AF were NOT prescribed warfarin if they are Thrombocytopenic (platelets <100 x 109/U).	[2]	5	7	Consensus-based recommendations	O
128	AF	Patients with AF were NOT prescribed warfarin if they have active bleeding: • Active peptic ulcer disease; • Maleana; • Haematemesis.	[2]	5	4	Consensus-based recommendations	O
129	AF	Patients with AF were NOT prescribed warfarin if they have severe hepatic disease.	[2]	5	7	Consensus-based recommendations	O
130	AF	Patients with AF were NOT prescribed warfarin who have a high risk of falls.	[2]	5	8	Consensus-based recommendations	O
131	AF	Patients presenting with AF for more than 48 hours duration or unknown duration with a CHADS2 score of 0, were prescribed low dose aspirin (unless contraindicated).	[2]	5	A[¥]	Consensus-based recommendations	U
132	AF	Patients presenting with AF for more than 48 hours duration or unknown duration with a CHADS2 score of 1, were prescribed warfarin or aspirin (unless contraindicated).	[2]	5	A[¥]	Consensus-based recommendations	U
133	AF	Patients presenting with AF for more than 48 hours duration or unknown duration with a CHADS2 score of 2, were prescribed warfarin (unless contraindicated).	[2]	5	A[¥]	Consensus-based recommendations	U
134	AF	Patients with chronic AF, who cannot be prescribed warfarin or decline warfarin therapy were prescribed aspirin.	[2]	5	7	Consensus-based recommendations	U
135	AF	Patients with AF that presented with new onset ischemic or embolic stroke were commenced on warfarin within 2 weeks of presentation (unless warfarin contraindicated).	[2]	5	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
136	AF	Patients with AF that presented with new onset Transient Ischemic Attack (TIA) were commenced on warfarin within 1 week of presentation (unless warfarin contraindicated).	[2]	5	8	Consensus-based recommendations	U
137	AF	Patients with AF > 48 hours or of unknown duration undergoing elective electrical or chemical cardioversion that did not have a Trans Oesophageal Echocardiogram within 24 hours of cardioversion were prescribed anticoagulants for at least 3 weeks prior to cardioversion.	[2]	5	8	Consensus-based recommendations	U
138	AF	Patients with AF > 48 hours duration or unknown duration having cardioversion, were prescribed anticoagulants for at least 4 weeks after cardioversion (unless contraindicated).	[2]	5	9	Consensus-based recommendations	U
139	AF	Patients with AF commenced on warfarin had an INR checked within 3 to 4 days of the first dose.	[2]	5	8	Consensus-based recommendations	U
140	CVA	Patients were assessed for TIA or stroke at the initial point of healthcare contact using the ABCD tool.	[13]	3	5	Level II Grade B	U
141	CVA	Patients at high risk (ABCD >4) or whose condition deteriorated rapidly had an urgent CT brain performed within 24hrs.	[13]	3	9	Level II Grade B	U
142	CVA	Patients at high risk (ABCD >4) or whose condition deteriorated rapidly had a carotid duplex ultrasound (if carotid revascularisation is an option) was performed within 24hrs.	[13]	3	8	Level II Grade B	U
143	CVA	Patients at low risk (ABCD < 4) had a CT brain performed within 48hrs.	[13]	3	6	Level II Grade B	U
144	CVA	Patients at low risk (ABCD <4) had a carotid duplex ultrasound performed within 48hrs.	[13]	3	6	Level II Grade B	U
145	CVA	Patients with a new diagnosis of stroke/TIA were admitted to a dedicated stroke unit.	[13]	3	9	Level 1 Grade A	U
146	CVA	Patients with a new diagnosis of a stroke/TIA have had a medical history documented.	[13]	3	9	Consensus-based recommendations	U
147	CVA	Patients with a new diagnosis of a stroke/TIA have had a neurological examination performed at the time of presentation.	[13]	3	9	Level II Grade C	U
148	CVA	Patients with a new diagnosis of a stroke/TIA had an assessment of functional status and swallowing performed prior to discharge.	[13]	3	8	Level I Grade C	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
149	CVA	Patients with a new diagnosis of a stroke/TIA have had a brain MRI scan with Diffusion Weighted Imaging (DWI) and a MRA of intracranial and extra cranial vessels.	[13]	3	A[¥]	Consensus-based recommendations	U
150	CVA	Patients with a new diagnosis of a stroke/TIA, that smoke were counselled to stop smoking.	[13]	3	8	Level I Grade A	U
151	CVA	Patients with a new diagnosis of a stroke/TIA have had a multidisciplinary team assessment within 2 days of admission which is documented in the medical records.	[13]	3	9	Consensus-based recommendations	U
152	CVA	Patient presenting with a stroke/TIA have had a complete blood picture, electrolytes and glucose measured at presentation.	[13]	3	8	Consensus-based recommendations	U
153	CVA	Patients presenting with a stroke/TIA have had their lipids (low density lipoprotein (LDL), Total cholesterol, high density lipoprotein (HDL), triglycerides) measured at presentation.	[13]	3	8	Consensus-based recommendations	U
154	CVA	Patients presenting with a stroke/TIA have had their CRP measured at presentation.	[13]	3	7	Consensus-based recommendations	U
155	CVA	Patients presenting with a stroke/TIA have had an ECG performed at presentation.	[13]	3	9	Consensus-based recommendations	U
156	CVA	Patients presenting with a stroke/TIA have had their renal function assessed at presentation.	[13]	3	8	Consensus-based recommendations	U
157	CVA	Patients aged > 18 years were prescribed IV Ateplase within 4.5 hours of the onset of ischeamic stroke.	[13]	3	9	Level I Grade A	U
158	CVA	Patients aged >18yrs with a clinically significant deficit on National Institutes of Health (NIH) Stroke Scale examination were prescribed IV Ateplase.	[13]	3	9	Level I Grade A	U
159	CVA	Patient aged > 18 years whose CT head does not show a haemorrhage or a non-vascular cause of stroke were prescribed IV Ateplase.	[13]	3	9	Level I Grade A	U
160	CVA	Patients prescribed IV Ateplase were admitted to a intensive care unit/coronary care unit/ED and/or dedicated stroke unit to have the drug administered.	[13]	3	8	Consensus-based recommendations	U
161	CVA	Patients prescribed IV Ateplase were monitored for signs of bleeding during its administration.	[13]	3	8	Level I and IV Grade C	U
162	CVA	Patients with an ischaemic stroke /TIA were NOT managed with intravenous un-fractionated heparin.	[13]	3	9	Level I Grade A	O
163	CVA	Aspirin (150-300mg) was administered within 48 hours of the onset of stroke symptoms if haemorrhage was excluded on CT brain.	[13]	3	9	Level I Grade A	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
164	CVA	Patients with a mild/moderate disability were referred to an multidisciplinary community rehab service.	[13]	3	8	Level I Grade A	U
165	CVA	Patients with a mild/moderate disability were referred to carer support services.	[13]	3	7	Level I Grade A	U
166	CVA	Patients with a stroke where death is imminent, a discussion with patient and/or family carer re no active treatment/NFR status been recorded in the medical record.	[13]	3	8	Consensus-based recommendations	U
167	CVA	Patients with a stroke where death is imminent, has a Not For Resuscitation (NFR) status/good palliative care order been documented in the medical record.	[13]	3	8	Consensus-based recommendations	U
168	CVA	Patients who have had more than one TIA or likely to have carotid surgery that did not have the cause of the ischaemic event identified at initial assessment had a transoesophageal echocardiogram performed.	[13]	3	8	Level I and Level III-2 Grade B	U
169	CVA	Patients who have had more than one TIA or likely to have carotid surgery that did not have the cause of the ischaemic event identified at initial assessment had a CT or MRA of intracranial/extra cranial vessels.	[13]	3	A[¥]	Level I and Level III-2 Grade B	U
170	CVA	Patients who have had more than one TIA or likely to have carotid surgery that did not have the cause of the ischaemic event identified at initial assessment had a Doppler ultrasound (carotid) performed.	[13]	3	8	Level I and Level III-2 Grade B	U
171	CVA	Patients where the underlying cause of the stroke/TIA was not confirmed had a chest x-ray performed.	[13]	3	8	Consensus-based recommendations	U
172	CVA	Patients where the underlying cause of the stroke/TIA was not confirmed had a MRI performed.	[13]	3	A[¥]	Consensus-based recommendations	U
173	CVA	Patients where the underlying cause of the stroke/TIA was not confirmed had syphilis serology performed.	[13]	3	7	Consensus-based recommendations	U
174	CVA	Patients where the underlying cause of the stroke/TIA was not confirmed were screened for vasculitis and thromboembolism.	[13]	3	7	Consensus-based recommendations	U
175	CAP[$]	Patients presenting with clinical signs suggestive of pneumonia had an urgent chest x-ray performed.	[1, 14, 15]	2	8	Consensus-based recommendations	U
176	CAP[$]	Patients presenting with clinical signs suggestive of pneumonia had blood and sputum cultures taken.	[1, 14, 15]	2	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
177	CAP[$]	Patients presenting with clinical signs suggestive of pneumonia had the following blood tests performed: • Electrolytes; • Urea; • Creatinine; • Glucose; • Liver Function Tests (LFTs); • Complete Blood Examination (CBE) and differential.	[1, 14, 15]	2	8	Consensus-based recommendations	U
178	CAP[$]	Patients presenting with clinical signs suggestive of pneumonia had their oxygen saturation measured.	[1, 14, 15]	2	9	Consensus-based recommendations	U
179	CAP[$]	Patients presenting with clinical signs suggestive of pneumonia with a arterial oxygen saturation (SaO2) reading < 94% had an arterial blood gas taken.	[1, 14, 15]	2	9	Consensus-based recommendations	U
180	CAP[$]	Patients with consolidation on their x-ray had their pneumonia severity assessed with the CURB-65 tool or the Pneumonia Severity Index (PSI) and had the result documented in the medical record.	[1, 14, 15]	2	8	Consensus-based recommendations	U
181	CAP[$]	Patients with a CURB-65 score <= 1 or a PSI score <= 70 were managed as an outpatient.	[1, 14, 15]	2	7	Consensus-based recommendations	U
182	CAP[$]	Patients with a CURB-65 score <= 1 or a PSI score <= 70 were prescribed oral amoxicillin 1g tds for at least 7 days. (oral cefuroxime 500mg BD if allergy to penicillin).	[1, 14, 15]	2	7	Consensus-based recommendations	U
183	CAP[$]	Patients with a CURB-65 score <= 1 or a PSI score <= 70 were prescribed at least one of the following: • Doxycycline 200mg as first dose, then 100mg daily for at least 5 days; • Roxithromycin 300mg daily for at least 5 days; • Clarithromycin 250mg bd for at least 7 days.	[1, 14, 15]	2	7	Consensus-based recommendations	U
184	CAP[$]	Patients with a CURB-65 score <= 1 or a PSI score <= 70 had a repeat chest x-ray within 4 weeks and reviewed a medical OPD or GP clinic to ensure resolution.	[1, 14, 15]	2	6	Consensus-based recommendations	U
185	CAP[$]	Patients with a CURB-65 score <= 1 or a PSI score <= 70 were reviewed within 48 hours of presentation.	[1, 14, 15]	2	6	Consensus-based recommendations	U
186	CAP[$]	Patients with a CURB-65 score <= 1 or a PSI score <= 70 were advised to seek medical attention if their condition worsened.	[1, 14, 15]	2	6	Consensus-based recommendations	U
187	CAP[$]	Patients with a PSI score between 71-90 were admitted to hospital.	[1, 14,	2	9	Consensus-based	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
			15]			recommendations	
188	CAP[$]	Patients with a PSI score between 71-90 were prescribed oral azithromycin 500mg daily for 5 days.	[1, 14, 15]	2	8	Consensus-based recommendations	U
189	CAP[$]	Patients with a PSI score between 71-90 were prescribed oral augmentin duo forte, one twice daily for at least 7 days (oral cefuroxime 500mg BD if allergy to penicillin).	[1, 15]	2	6	Consensus-based recommendations	U
190	CAP[$]	Patients with a PSI score between 71 - 90 had a repeat chest x-ray within 4 weeks and a medical OPD or GP clinic. to ensure resolution.	[1, 15]	2	6	Consensus-based recommendations	U
191	CAP[$]	Patients with a CURB-65 score = 2 or a PSI score between 91 - 130 were admitted to hospital.	[1, 14, 15]	2	9	Consensus-based recommendations	U
192	CAP[$]	Patients with a CURB-65 score = 2 or a PSI score between 91 - 130 were prescribed oral azithromycin 500mg daily for 5 days.	[1, 14, 15]	2	8	Consensus-based recommendations	U
193	CAP[$]	Patients with a CURB-65 score = 2 or a PSI score between 91 - 130 were prescribed penicillin 1.2g IV every 6 hours for at least 7 days (Ceftriaxone 1g IV daily if allergy to penicillin).	[1, 14, 15]	2	8	Consensus-based recommendations	U
194	CAP[$]	Patients with a CURB-65 score = 2 or a PSI score between 91 - 130 were prescribed 2 stat IV doses of gentamicin 5mg/kg.	[1, 14, 15]	2	8	Consensus-based recommendations	U
195	CAP[$]	Patients with a CURB-65 score = 2 or a PSI score between 91 - 130 with evidence of gram negative bacilli or no improvement after 3 days were referred for an infectious disease consult.	[1, 14, 15]	2	8	Consensus-based recommendations	U
196	CAP[$]	Patients with a CURB 65 score > 3 or a PSI score > 130 were admitted to an intensive care unit.	[1, 14, 15]	2	9	Consensus-based recommendations	U
197	CAP[$]	Patients with a CURB 65 score > 3 or a PSI score > 130 were prescribed azithromycin 500mg IV daily for 10 days.	[1, 14, 15]	2	9	Consensus-based recommendations	U
198	CAP[$]	Patients with a CURB 65 score > 3 or a PSI score > 130 were prescribed penicillin 1.2g IV every 6 hours for 10 days (Ceftriaxone 1g IV daily if allergy to penicillin).	[1, 14, 15]	2	8	Consensus-based recommendations	U
199	CAP[$]	Patients with a CURB 65 score > 3 or a PSI score > 130 were prescribed 2 stat IV doses of gentamicin 5mg/kg.	[1, 14, 15]	2	8	Consensus-based recommendations	U
200	CAP[$]	Patients with community acquired pneumonia admitted to hospital had a sputum sample obtained for gram stain and culture, inclusive of legionella screening on admission.	[1, 15]	2	9	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
201	CAP[$]	Patients with community acquired pneumonia admitted to hospital had a nasopharyngeal aspirate/swab or sputum sample obtained to screen for viral detection on admission.	[1, 15]	2	9	Consensus-based recommendations	U
202	CAP[$]	Patients with community acquired pneumonia admitted to hospital had a urine sample sent for legionella screening on admission.	[1, 15]	2	8	Consensus-based recommendations	U
203	CAP[$]	Patients with community acquired pneumonia admitted to hospital had serum serology samples sent for detection of respiratory viruses; mycoplasma, Chlamydia, legionella antibodies on admission.	[1, 15]	2	8	Consensus-based recommendations	U
204	CAP[$]	Patients with community acquired pneumonia admitted to hospital had serum serology samples sent for detection of respiratory viruses; mycoplasma, Chlamydia, legionella antibodies within 14 days if the admission samples did not provide a diagnosis.	[1, 15]	2	8	Consensus-based recommendations	U
205	CAP[$]	Patients with community acquired pneumonia admitted to hospital who had a pleural effusion or empyema on chest x-ray had a pleural aspirate performed (+/-ultrasound guidance).	[1, 15]	2	9	Consensus-based recommendations	U
206	CAP[$]	Patients with community acquired pneumonia admitted to hospital who had a pleural effusion or empyema on chest x-ray had pleural aspirates tested for pH, gram stain culture, protein, lactate dehydrogenase (LDH) and cell count.	[1, 15]	2	9	Consensus-based recommendations	U
207	CAP[$]	Patient treated with pneumonia were advised to have a follow up appointment within 6 weeks of either discharge or diagnosis.	[1, 15]	2	9	Consensus-based recommendations	U
208	COPD	Patients diagnosed with COPD had their co-morbidities documented in the medical record.	[2, 16]	3	8	Consensus-based recommendations	U
209	COPD	Patients diagnosed with COPD had their smoking status and/or a previous smoking history documented in the medical record.	[2, 16]	3	8	Level I	U
210	COPD	Patients diagnosed with COPD had their influenza vaccination status documented in the medical record.	[2, 16]	3	9	Level I	U
211	COPD	Patients diagnosed with COPD had their lung function (including spirometry) assessed to confirm the diagnosis.	[2, 16]	3	8	Level II	U
212	COPD	Patients diagnosed with COPD had an electrocardiogram (ECG) performed (or ordered) to confirm the diagnosis.	[2, 16]	3	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
213	COPD	Patients diagnosed with COPD with any of the following: FEV1 <40% or <1L; SaO2 < 92% on air, pulmonary hypertension or extreme breathlessness had a blood gas analysis performed to confirm the diagnosis.	[2, 16]	3	6	Consensus-based recommendations	U
214	COPD	Patients diagnosed with COPD had a chest x-ray taken (or ordered) to confirm the diagnosis.	[2, 16]	3	8	Consensus-based recommendations	U
215	COPD	COPD patients who currently smoke were counselled to stop smoking and the advice was documented.	[2, 16]	3	8	Level I	U
216	COPD	COPD patients who currently smoke and wish to quit were advised to use nicotine replacement therapy.	[2, 16]	3	7	Level I	U
217	COPD	COPD patients prescribed theophylline had the level checked within one week of either drug commencement or an increase in dose.	[2]	3	5	Consensus-based recommendations	U
218	COPD	COPD patients prescribed theophylline with a serum theophylline level exceeding 20mg/ml, had the dose modified within 1 day of the measurement.	[2]	3	6	Consensus-based recommendations	U
219	COPD	COPD patients prescribed theophylline and the serum theophylline exceeded 20mg/ml, had the level rechecked within one week or the medication ceased.	[2]	3	7	Consensus-based recommendations	U
220	COPD	Patients with COPD with a baseline room air saturation of <=90% , who have stopped smoking were prescribed home oxygen.	[2, 16]	3	7	Consensus-based recommendations	U
221	COPD	Patients with existing COPD are involved in a pulmonary rehabilitation program for long term management of the disease.	[2, 16]	3	8	Level I	U
222	COPD	Patients with existing COPD had an annual spirometry test performed for long term management of the disease.	[2, 16]	3	8	Consensus-based recommendations	U
223	COPD	Patients with existing COPD had annual assessment of their inhaler technique for long term management of the disease.	[2, 16]	3	7	Consensus-based recommendations	U
224	COPD	Patients with existing COPD were given care to prevent or treat osteoporosis for long term management of the disease.	[2, 16]	3	8	Consensus-based recommendations	U
225	COPD	Patients with existing COPD were assessed every year for pulmonary hypertension.	[2, 16]	3	7	Level I	U
226	COPD	Patients with existing COPD that is moderate/severe and/or they have frequent exacerbations were treated with inhaled glucocorticoids.	[2, 16]	3	8	Level I	U
227	COPD	Patients with existing COPD have an action plan for the management of an exacerbation.	[2, 16]	3	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
228	COPD	COPD patients administered oxygen have a prescribed order in the medical records.	[2, 16]	3	7	Consensus-based recommendations	U
229	COPD	Patients who present with an acute exacerbation of COPD had a current list of medications documented in the medical records.	[2, 16]	3	8	Consensus-based recommendations	U
230	COPD	Patients who present with an acute exacerbation of COPD had information on prior hospitalizations, urgent care, or ED visits documented in the medical records.	[2, 16]	3	8	Consensus-based recommendations	U
231	COPD	Patients who present with an acute exacerbation of COPD were assessed for the presence or absence of a new cough.	[2, 16]	3	8	Consensus-based recommendations	U
232	COPD	Patients who present with an acute exacerbation of COPD had their vital signs recorded (respiratory rate, pulse, temperature, blood pressure).	[2, 16]	3	8	Consensus-based recommendations	U
233	COPD	Patients who present with an acute exacerbation of COPD had a chest examination performed.	[2, 16]	3	8	Consensus-based recommendations	U
234	COPD	Patients who present with an acute exacerbation of COPD had a chest x-ray performed.	[2, 16]	3	9	Consensus-based recommendations	U
235	COPD	Patients who present with an acute exacerbation of COPD had blood gas analysis performed.	[2, 16]	3	8	Consensus-based recommendations	U
236	COPD	Patients who present with an acute exacerbation of COPD with a history of coronary disease had an ECG performed within 24hrs of presentation.	[2]	3	7	Consensus-based recommendations	U
237	COPD	Patients who present with an acute exacerbation of COPD, who also take theophylline, had a theophylline level performed at presentation.	[2]	3	5	Consensus-based recommendations	U
238	COPD	Patients who present with an acute exacerbation of COPD, with oxygen (O2) saturation <90% or arterial oxygen tension (PaO2) is <55 mmHg had oxygen administered.	[2, 16]	3	9	Consensus-based recommendations	U
239	COPD	Patients who present with an acute exacerbation of COPD who had myocardial ischaemia documented was admitted to hospital.	[2, 16]	3	9	Consensus-based recommendations	U
240	COPD	Patients who present with an acute exacerbation of COPD that had signs of severe dyspnoea (respiratory rate (RR) >35) and were for active resuscitation was admitted to critical care or respiratory unit.	[2, 16]	3	6	Consensus-based recommendations	U
241	COPD	Patients who present with an acute exacerbation of COPD, that was not for active resuscitation was referred to palliative care.	[2, 16]	3	A[¥]	Consensus-based recommendations	U
242	COPD	Patients who present with an acute exacerbation of COPD that had oxygen saturation <90% and is a non-smoker was discharged with home oxygen.	[2, 16]	3	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
243	COPD	Patients who present with an acute exacerbation of COPD was administered inhaled bronchodilators.	[2, 16]	3	9	Level I	U
244	COPD	Patients who present with an acute exacerbation of COPD was prescribed systemic glucocorticoids.	[2, 16]	3	9	Level I	U
245	COPD	Patients who present with an acute exacerbation of COPD was prescribed antibiotics if clinical signs of infection were present.	[2, 16]	3	9	Level I	U
246	COPD	Patients who present with an acute exacerbation of COPD was managed with non-invasive ventilation for acute hypercapnic ventilator failure.	[2, 16]	3	8	Level I	U
247	CHF	Patients with new diagnosis of heart failure had evaluation of ejection fraction within one month of diagnosis.	[2]	5	8	Consensus-based recommendations	U
248	CHF	Patients with heart failure were assessed for presence/absence of prior MI or cardiac disease at diagnosis.	[2]	5	8	Consensus-based recommendations	U
249	CHF	Patients with heart failure were assessed for presence or absence of current symptoms of chest discomfort or angina at diagnosis.	[2]	5	9	Consensus-based recommendations	U
250	CHF	Patients with heart failure were assessed for hypertension at diagnosis.	[2]	5	9	Consensus-based recommendations	U
251	CHF	Patients with heart failure were assessed for diabetes at diagnosis.	[2]	5	9	Consensus-based recommendations	U
252	CHF	Patients with heart failure had current medications documented at diagnosis.	[2]	5	9	Consensus-based recommendations	U
253	CHF	Patients with heart failure had current alcohol intake documented at diagnosis.	[2]	5	9	Consensus-based recommendations	U
254	CHF	Patients with heart failure had smoking status documented at diagnosis.	[2]	5	9	Consensus-based recommendations	U
255	CHF	Patients with heart failure were assessed for history of recent viral infection at diagnosis.	[2]	5	A$^{¥}$	Consensus-based recommendations	U
256	CHF	Patients with heart failure were assessed for history of chemotherapy or radiotherapy at diagnosis.	[2]	5	A$^{¥}$	Consensus-based recommendations	U
257	CHF	Patients with heart failure were assessed for obstructive sleep apnoea at diagnosis.	[2]	5	A$^{¥}$	Consensus-based recommendations	U
258	CHF	Patients with heart failure were assessed for history of AF/ Paroxysmal	[2]	5	A$^{¥}$	Consensus-based	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
		supraventricular tachycardia (PSVT) at diagnosis.				recommendations	
259	CHF	Patients with heart failure were assessed using New York Heart Association Failure status or equivalent at diagnosis.	[2]	5	9	Consensus-based recommendations	U
260	CHF	Patients with a new diagnosis of heart failure had their weight recorded at presentation.	[2]	5	8	Consensus-based recommendations	U
261	CHF	Patients with a new diagnosis of heart failure had their blood pressure performed and recorded at presentation.	[2]	5	9	Consensus-based recommendations	U
262	CHF	Patients with a new diagnosis of heart failure had a lung exam performed and recorded at presentation.	[2]	5	8	Consensus-based recommendations	U
263	CHF	Patients with a new diagnosis of heart failure had a cardiac exam performed and recorded at presentation.	[2]	5	9	Consensus-based recommendations	U
264	CHF	Patients with a new diagnosis of heart failure had an abdominal exam performed and recorded at presentation.	[2]	5	8	Consensus-based recommendations	U
265	CHF	Patients with a new diagnosis of heart failure had a lower extremity exam performed and recorded at presentation.	[2]	5	8	Consensus-based recommendations	U
266	CHF	Patients with a new diagnosis of heart failure had an examination of their neck veins performed and recorded at presentation.	[2]	5	9	Consensus-based recommendations	U
267	CHF	Patients with a new diagnosis of heart failure had their heart rate assessed and recorded at presentation.	[2]	5	9	Consensus-based recommendations	U
268	CHF	If not recorded in the previous 3 months, patients with a new diagnosis of heart failure had a chest x-ray within one month of diagnosis.	[2]	5	8	Consensus-based recommendations	U
269	CHF	If not recorded in the previous 3 months, patients with a new diagnosis of heart failure had an ECG within one month of diagnosis.	[2]	5	9	Consensus-based recommendations	U
270	CHF	If not recorded in the previous 3 months, patients with a new diagnosis of heart failure had a complete blood count within one month of diagnosis.	[2]	5	9	Consensus-based recommendations	U
271	CHF	If not recorded in the previous 3 months, patients with a new diagnosis of heart failure had a serum sodium, potassium and bicarbonate test within one month of diagnosis.	[2]	5	9	Consensus-based recommendations	U
272	CHF	If not recorded in the previous 3 months, patients with a new diagnosis of heart failure had a serum creatinine test within one month of diagnosis.	[2]	5	9	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
273	CHF	Patients with symptoms of heart failure who were hospitalised had their weight recorded on admission.	[2]	5	9	Consensus-based recommendations	U
274	CHF	Patients with symptoms of heart failure who were hospitalised had their blood pressure recorded on admission.	[2]	5	9	Consensus-based recommendations	U
275	CHF	Patients with symptoms of heart failure who were hospitalised had a lung examination recorded on admission.	[2]	5	9	Consensus-based recommendations	U
276	CHF	Patients with symptoms of heart failure who were hospitalised had a cardiac examination recorded on admission.	[2]	5	9	Consensus-based recommendations	U
277	CHF	Patients with symptoms of heart failure who were hospitalised had an abdominal examination recorded on admission.	[2]	5	9	Consensus-based recommendations	U
278	CHF	Patients with symptoms of heart failure who were hospitalised had a lower extremity examination recorded on admission.	[2]	5	9	Consensus-based recommendations	U
279	CHF	Patients with symptoms of heart failure who were hospitalised had an examination of neck veins recorded on admission.	[2]	5	9	Consensus-based recommendations	U
280	CHF	Patients with symptoms of heart failure who were hospitalised had heart rate measured and recorded on admission.	[2]	5	9	Consensus-based recommendations	U
281	CHF	Patients with symptoms of heart failure who were hospitalised had serum electrolytes within one day of admission.	[2]	5	9	Consensus-based recommendations	U
282	CHF	Patients with symptoms of heart failure who were hospitalised had a serum creatinine test within one day of admission.	[2]	5	9	Consensus-based recommendations	U
283	CHF	Patients with heart failure with ejection fraction< 40% were prescribed an Angiotensin-converting enzyme (ACE) inhibitor (unless contraindicated).	[2]	5	8	Consensus-based recommendations	U
284	CHF	Patients with heart failure prescribed an ACE inhibitor had a serum creatinine and potassium measured within 2 weeks.	[2]	5	7	Consensus-based recommendations	U
285	CHF	Patients with heart failure prescribed an ACE inhibitor and clinically unwell had a serum creatinine and potassium measured.	[2]	5	A[¥]	Consensus-based recommendations	U
286	CHF	Patients with heart failure prescribed an ACE inhibitor had a serum creatinine and potassium measurement performed at least every 6 months.	[2]	5	7	Consensus-based recommendations	U
287	CHF	Patients with heart failure that were treated medically received dietary counselling within one month of starting medical treatment.	[2]	5	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
288	CHF	Patients hospitalised with heart failure were advised to see a GP or Specialist within 4 weeks of discharge.	[2]	5	8	Consensus-based recommendations	U
289	CAD	Patients with a new diagnosis of CAD were prescribed aspirin within 1 week of the diagnosis (unless contraindicated).	[2]	5	8	Consensus-based recommendations	U
290	CAD	Patients with a new diagnosis of CAD were asked about their smoking status and counselled to stop if current smoker.	[2]	5	9	Consensus-based recommendations	U
291	CAD	Patients with a new diagnosis of CAD had a 12 lead ECG performed at the time of diagnosis.	[2]	5	9	Consensus-based recommendations	U
292	CAD	Patients that presented with chest pain for a suspected acute coronary syndrome (ACS) or unstable angina received aspirin at the time of presentation by emergency or ambulance personnel, unless already taken or contraindicated.	[17]	5	A[¥]	Grade A	U
293	CAD	Patients presenting with acute myocardial infarction (MI) had a 12 lead ECG performed at the time of presentation or during ambulance transport.	[17]	5	A[¥]	Grade B	U
294	CAD	Patients presenting with acute MI had cardiac markers (Troponin, Total Creatine Kinase (CK), CK-MB level) at the time of presentation.	[17]	5	A[¥]	Consensus-based recommendations	U
295	CAD	Patients admitted within 12 hours of the onset of acute MI received anti-thrombin therapy - heparin, enoxaparin (subcutaneously or IV) for at least 24 hours unless they had already received streptokinase, Anisoylated Plasminogen Streptokinase Activator Complex (APSAC), or urokinase (unless contraindicated).	[17]	5	7	Grade D	U
296	CAD	Patients hospitalised with an MI, that had risk factors for a low left ventricular ejection fraction (LVEF), had an assessment of their LVEF prior to discharge.	[2]	5	8	Consensus-based recommendations	U
297	CAD	Patients hospitalised with an MI that also have a history of prior MI, but no risk factors for low LVEF had an assessment of their LVEF during hospitalisation or within 2 weeks of discharge.	[2]	5	7	Consensus-based recommendations	U
298	CAD	Patients that presented with a acute myocardial infarction had one of the following reperfusion treatments offered; • Percutaneous coronary intervention; • Fibrinolysis (if not contraindicated.	[17]	5	7	Level I	U
299	CAD	Patients admitted to hospital with an acute MI had their BP documented.	[2]	5	9	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
300	CAD	Patients admitted to hospital with an acute MI had their heart rate documented.	[2]	5	9	Consensus-based recommendations	U
301	CAD	Patients admitted to hospital with an acute MI had a heart examination documented.	[2]	5	9	Consensus-based recommendations	U
302	CAD	Patients admitted to hospital with an acute MI had lung examination documented.	[2]	5	9	Consensus-based recommendations	U
303	CAD	Patients that were discharged after an acute MI were discharged on aspirin (unless contraindicated).	[2, 17]	5	9	Level I Grade A	U
304	CAD	Patients that were discharged after an acute MI were discharged on a beta blocker (unless contraindicated).	[2, 17]	5	8	Level I Grade A	U
305	CAD	Patients that were discharged after an acute MI were discharged on an ACE inhibitor (unless contraindicated).	[17]	5	A[¥]	Level II Grade B	U
306	CAD	Patients that were discharged after an acute MI were discharged on an anti platelet agent (unless contraindicated).	[17]	5	A[¥]	Level I Grade A	U
307	CAD	Patients that were discharged after an acute MI were discharged on a cholesterol lowering medication (unless contraindicated).	[17]	5	A[¥]	Level II Grade B	U
308	CAD	Patients with CAD that were found to have 3 vessel CAD and an LVEF <= 40% at the time of coronary angiography had percutaneous transluminal coronary angioplasty (PTCA) or Coronary artery bypass surgery (CABS) within 1 month of angiogram (unless contraindicated - extreme age, non-consent, technically not possible).	[2]	5	8	Consensus-based recommendations	U
309	CAD	Patients with CAD that were found to have left main stenosis > 50% at the time of coronary angiography had CABS within 1 month of angiogram (unless contraindicated - extreme age, non-consent, technically not possible).	[2]	5	7	Consensus-based recommendations	U
310	CAD	Patients being evaluated for unstable angina had their BP recorded at the time of presentation.	[2]	5	9	Consensus-based recommendations	U
311	CAD	Patients being evaluated for unstable angina had their heart rate measured and recorded at the time of presentation.	[2]	5	9	Consensus-based recommendations	U
312	CAD	Patients being evaluated for unstable angina had a heart examination performed and recorded at the time of presentation.	[2]	5	9	Consensus-based recommendations	U
313	CAD	Patients being evaluated for unstable angina had a lung examination performed and recorded at the time of presentation.	[2]	5	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
314	CAD	Patients being evaluated for unstable angina had a 12 lead ECG performed at the time of presentation.	[2]	5	9	Consensus-based recommendations	U
315	CAD	Patients being evaluated for unstable angina had their Haemoglobin/Haematocrit measured and recorded at the time of presentation.	[2]	5	7	Consensus-based recommendations	U
316	CAD	Patients admitted to hospital with unstable angina lasting > 5 mins at rest and associated with ST segment changes were administered heparin within 2 hours of the initial ECG showing ST changes and a continuous heparin infusion or subcutaneous LMWH heparin for at least 24 hours (unless contraindicated).	[2]	5	9	Consensus-based recommendations	U
317	CAD	Patients admitted to hospital with unstable angina lasting > 5 mins at rest and associated with ST segment changes were administered beta blockers within 4 hours (unless contraindicated).	[2]	5	8	Consensus-based recommendations	U
318	CAD	Patients admitted to hospital with unstable angina were placed on a cardiac monitor unless they were NFR or for palliative measures only.	[2]	5	7	Consensus-based recommendations	U
319	CAD	Patients admitted to hospital with unstable angina had a repeat 12 lead ECG between 4 and 6 hours post admission.	[2]	5	8	Consensus-based recommendations	U
320	CAD	Patients admitted to hospital with unstable angina had their haemoglobin/haematocrit measured.	[2]	5	8	Consensus-based recommendations	U
321	CAD	Patients admitted to hospital with unstable angina had serial troponins measured.	[2]	5	7	Consensus-based recommendations	U
322	CAD	Patients with CAD admitted to hospital who had Left bundle branch block (LBBB) identified on resting ECG had their LVEF measured (via echo, ventriculogram or radionuclide scan) during the admission or within 10 days of discharge.	[2]	5	6	Consensus-based recommendations	U
323	CAD	Patients with CAD admitted to hospital who had cardiomegaly identified on examination or on chest x-ray had measurement of their Left Ventricular Ejection Fraction (LEVF)(via echocardiograph, ventriculogram or radionuclide scan) during the admission or within 10 days of discharge.	[2]	5	8	Consensus-based recommendations	U
324	CAD	Patients with CAD admitted to hospital who had heart failure diagnosed during the admission had measurement of their LVEF (via echocardiograph, ventriculogram or radionuclide scan) during the admission or within 10 days of discharge.	[2]	5	8	Consensus-based recommendations	U
325	CAD	Patients admitted after cardiac arrest had coronary angiography before discharge (unless revascularisation contraindicated or Not For Resuscitation or palliative care only).	[2]	5	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
326	CAD	Patients with CAD that had a high risk stress test had coronary angiography performed within 6 weeks of the stress test (unless revascularization contraindicated).	[2]	5	7	Consensus-based recommendations	U
327	DE	Patients newly diagnosed with depression had alcohol intake /other drug use documented.	[2]	6	9	Consensus-based recommendations	U
328	DE	Patients newly diagnosed with depression had a family history of depression documented.	[2]	6	$A^{¥}$	Consensus-based recommendations	U
329	DE	Patients newly diagnosed with depression had their life stressors documented.	[2]	6	$A^{¥}$	Consensus-based recommendations	U
330	DE	Patients newly diagnosed with depression had their support measures documented.	[2]	6	$A^{¥}$	Consensus-based recommendations	U
331	DE	Patients newly diagnosed with depression had their current medications documented.	[2]	6	9	Consensus-based recommendations	U
332	DE	Patients newly diagnosed with depression had their co-morbidities documented.	[2]	6	9	Consensus-based recommendations	U
333	DE	Patients newly diagnosed with depression had their suicidal ideation/intent documented.	[2]	6	9	Consensus-based recommendations	U
334	DE	Within 2 weeks of a diagnosis of depression, patient was treated with one of the following: • Psychological therapy (cognitive behavioural therapy); • Pharmacological therapy; • Self-help (bibliotherapy - written material on cognitive behavioural therapy (CBT)).	[2]	6	5	Consensus-based recommendations	U
335	DE	Patients with depression who have suicidal ideation documented were asked if they had plans to carry out suicide.	[2]	6	9	Consensus-based recommendations	U
336	DE	Patients with depression who have suicidal ideation and signs of psychosis were hospitalised.	[2]	6	8	Consensus-based recommendations	U
337	DE	Patients with depression who have suicidal ideation and current alcohol or drug abuse or dependence were hospitalised.	[2]	6	5	Consensus-based recommendations	U
338	DE	Patients with depression who have suicidal ideation and have specific plans to carry out suicide were hospitalised.	[2]	6	9	Consensus-based recommendations	U
339	DE	Patients were NOT prescribed an anti-anxiety agent as the sole treatment for their depression.	[2]	6	7	Consensus-based recommendations	O

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
340	DE	Within 2 weeks of a diagnosis of depression patients had a medication review with their GP or Psychiatrist.	[2]	6	7	Consensus-based recommendations	U
341	DE	Within 2 weeks of a diagnosis of depression patients had telephone contact with their GP.	[2]	6	5	Consensus-based recommendations	U
342	DE	Patients that were hospitalised for depression were advised to see their mental health specialist or GP within 2 weeks of discharge.	[2]	6	8	Consensus-based recommendations	U
343	DE	Patients who show signs of improvement within 6 weeks of starting antidepressant treatment were continued on an antidepressant for at least 6mths.	[2]	6	4	Consensus-based recommendations	U
344	DE	Patients requiring treatment of their depression had the response to treatment or remission of depression assessed and documented (weekly, then monthly then every 3 months).	[2]	6	9	Consensus-based recommendations	U
345	DE	Patients with depression being treated with pharmacotherapy had an assessment for side effects performed and documented for 12 months following the commencement of the medication.	[2]	6	9	Consensus-based recommendations	U
346	DI	Patients newly diagnosed with type 2 diabetes had an eye and visual examination.	[2, 8]	3	4	Consensus-based recommendations	U
347	DI	Patients newly diagnosed with type 2 diabetes had their blood lipids (LDL, total cholesterol, HDL, Triglycerides) measured.	[2, 8]	3	9	Grade A	U
348	DI	Patients newly diagnosed with type 2 diabetes had their urinary micro-albumin (MA/Cr ration) measured.	[2, 8, 18]	3	8	Level III-2	U
349	DI	Patients newly diagnosed with type 2 diabetes were assessed for cardiovascular disease and atria fibrillation.	[2, 8]	3	5	Level III-2	U
350	DI	Patients newly diagnosed with type 2 diabetes were asked about their smoking history and advised to quit if current smoker.	[2, 8, 18]	3	8	Level I	U
351	DI	Patients newly diagnosed with type 2 diabetes were referred to a dietician or advised of an appropriate diet.	[2, 8, 19]	3	7	Level I	U
352	DI	Patients newly diagnosed with type 2 diabetes were involved in a discussion regarding an exercise regime.	[2, 8, 19]	3	9	Level I	U
353	DI	Patients newly diagnosed with type 2 diabetes were assessed for macro vascular disease (peripheral pulses, carotid bruits, chest pain, TIA).	[2, 8]	3	7	Level III-2	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)$^{+}$	Level of evidence	U/O**
354	DI	Patients with existing type 2 diabetes had an eye and visual examination at least once in the two years.	[2, 8]	3	5	Consensus-based recommendations	U
355	DI	Patients with existing type 2 diabetes had their glycated hemoglobin (HBA1c) levels measured every 6 months.	[2, 8]	3	9	Grade A	U
356	DI	Patients with existing type 2 diabetes had their blood lipids (LDL, total cholesterol, HDL, Triglycerides) measured every year.	[2, 8]	3	8	Level III-2	U
357	DI	Patients with existing type 2 diabetes had their urinary micro-albumin (MA/Cr ratio) measured every year	[2, 8, 18]	3	5	Grade B	U
358	DI	Patients with existing type 2 diabetes were assessed for cardiovascular disease and AF every year.	[2, 8]	3	8	Level III-2	U
359	DI	Patients with existing type 2 diabetes were asked about their smoking status and advised to quit if current smoker.	[2, 8, 19]	3	7	Level I	U
360	DI	Patients with existing type 2 diabetes were referred to a dietician or provided with dietary advice every year.	[2, 8, 19]	3	9	Level I	U
361	DI	Patients with existing type 2 diabetes were involved in an annual discussion regarding an exercise regime.	[2, 8, 19]	3	7	Level I	U
362	DI	Patients with existing type 2 diabetes were assessed annually for macro vascular disease (peripheral pulses, carotid bruits, chest pain, TIA).	[2, 8]	3	6	Level III-2	U
363	DI	Patients with existing type 2 diabetes have a glucometer at home to measure their blood glucose levels (BGLs).	[2, 8]	3	8	Grade C	U
364	DI	Patients with existing type 2 diabetes that failed dietary therapy were commenced on oral hypoglycemics.	[2, 8]	3	8	Consensus-based recommendations	U
365	DI	Patients with existing type 2 diabetes that failed oral hypoglycaemics were offered insulin therapy.	[2, 8]	3	7	Consensus-based recommendations	U
366	DI	Patients who have diabetes and hypertension that is controlled by diet and exercise had their blood pressure measured every 6 months.	[2, 8]	3	9	Level III-2	U
367	DI	Patients who have diabetes and hypertension that is controlled with anti-hypertensive medication had their blood pressure measured every 3 months.	[2, 8]	3	6	Level III-2	U
368	DI	Patients with type 2 diabetes had a foot examination and received foot care education every 6 months.	[8]	3	9	Level I	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
369	DI	Patients who are diabetic and who have foot ulcers (high risk feet) were referred to a podiatrist.	[8]	3	8	Level III-2	U
370	DI	Patients with diabetic neuropathy were treated with angiotensin receptor blockers or angiotensin converting enzyme inhibitors.	[8, 18]	3	9	Level I	U
371	DI	Patients with type 2 diabetes and the blood pressure was >130/80mmHg were treated with angiotensin converting enzyme inhibitors or angiotensin receptor blockers.	[8, 18]	3	9	Level I	U
372	DI	Patients with type 2 diabetes and the blood pressure was >125/75mmHg in the presence of proteinuria were treated with angiotensin converting enzyme inhibitors or angiotensin receptor blockers.	[8, 18]	3	9	Level I	U
373	DY	Patients presenting with symptoms of dyspepsia were prescribed a proton pump inhibitor (PPI).	[20]	3	7	Level I Grade A	U
374	DY	Patients who have a positive test for H.Pylori received treatment.	[20]	3	8	Level I Grade A	U
375	DY	Patients presenting with symptoms of dyspepsia, without alarm signs, DID NOT have an endoscopy performed.	[2, 20]	3	4	Grade B	O
376	DY	Patients presenting with a new episode of dyspepsia had their current medication/s documented.	[2, 20]	3	9	Grade C	U
377	DY	Patients presenting with dyspepsia and significant unintentional weight loss (> 7kg in past 3 months) were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U
378	DY	Patients presenting with dyspepsia and progressive dysphagia were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U
379	DY	Patients presenting with dyspepsia and persistent vomiting were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U
380	DY	Patients presenting with dyspepsia and iron deficiency anaemia were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U
381	DY	Patients presenting with dyspepsia, with an epigastric mass were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
382	DY	Patients presenting with dyspepsia, with an abnormal barium meal result were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U
383	DY	Patients aged >55 years presenting with persistent and unexplained dyspepsia, were referred to a specialist and had an endoscopy performed within 2 weeks of presentation.	[20]	3	6	Grade B	U
384	DY	Patients with peptic ulcer disease (PUD) that are currently taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin had them ceased unless there was a valid reason to continue them documented.	[20]	3	8	Level I Grade A	U
385	DY	Patients diagnosed with PUD or Gastro Oesophageal Reflux Disease, (based on symptoms) were prescribed a high dose Proton Pump Inhibitor for at least 2 weeks.	[20]	3	4	Level I Grade A	U
386	DY	Patients diagnosed with PUD, PUD complications or endoscopically determined non ulcer dyspepsia that tested positive for H-Pylori were prescribed one of the following regimes: • Full dose PPI and BD metronidazole 400 mg and clarithromycin 250 mg; • Amoxicillin 1 g and clarithromycin 500 mg for 7 days.	[2, 20]	3	8	Level I Grade A	U
387	DY	Patients diagnosed with PUD, PUD complications or endoscopically determined non ulcer dyspepsia that tested positive for H-Pylori had further breath testing or biopsy to confirm eradication with one month if symptoms recurred within 6 months of the initial treatment.	[2, 20]	3	6	Consensus-based recommendations	U
388	DY	Patients diagnosed with PUD, PUD complications or endoscopically determined non ulcer dyspepsia that tested positive for H-Pylori were NOT re tested following eradication therapy if symptoms did not recur.	[20]	3	3	Grade C	O
389	DY	Patients diagnosed with PUD, PUD complications or endoscopically determined non ulcer dyspepsia have the results of all H-Pylori testing documented in the medical record.	[2]	3	9	Consensus-based recommendations	U
390	DY	Patients with a gastric ulcer visualised at endoscopy had a minimum of 3 biopsies performed and a follow up endoscopy within 3 months.	[2]	3	6	Consensus-based recommendations	U
391	DY	Patients who have endoscopically visualised PUD and have continued oozing or bleeding recorded have endoscopic treatment or surgery within 24 hours.	[2]	3	6	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)$^+$	Level of evidence	U/O**
392	DY	Patients who have endoscopically visualised PUD and have spurting of blood recorded have endoscopic treatment or surgery within 24 hours..	[2]	3	6	Consensus-based recommendations	U
393	DY	Patients who have endoscopically visualised PUD and have visible vessels (or pigmented protuberance) recorded have endoscopic treatment or surgery within 24 hours.	[2]	3	6	Consensus-based recommendations	U
394	DY	Patients requiring long-term management of symptoms for dyspepsia have their condition reviewed every year.	[2]	3	6	Level II Grade C	U
395	HYT	Patients newly diagnosed with hypertension had their current medication assessed and documented.	[2, 6]	4	9	Consensus-based recommendations	U
396	HYT	Patients newly diagnosed with hypertension had their alcohol intake assessed and documented.	[2, 6]	4	8	Consensus-based recommendations	U
397	HYT	Patients newly diagnosed with hypertension had their smoking history assessed and documented and advised to stop if current smoker (refer quitline).	[2, 6]	4	9	Consensus-based recommendations	U
398	HYT	Patients newly diagnosed with hypertension had their absolute cardiovascular risk assessed and documented.	[2, 6]	4	8	Consensus-based recommendations	U
399	HYT	Patients newly diagnosed with hypertension had their co-morbidities and end organ damage assessed and documented.	[2, 6]	4	8	Consensus-based recommendations	U
400	HYT	Patients newly diagnosed with hypertension had the causes of their secondary hypertension assessed and documented.	[2, 6]	4	8	Consensus-based recommendations	U
401	HYT	Patients newly diagnosed with hypertension had their blood pressure assessed and documented.	[2, 6]	4	9	Consensus-based recommendations	U
402	HYT	Patients newly diagnosed with hypertension had their pulse assessed and documented.	[2, 6]	4	9	Consensus-based recommendations	U
403	HYT	Patients newly diagnosed with hypertension had their fundi assessed and documented.	[2, 6]	4	7	Consensus-based recommendations	U
404	HYT	Patients newly diagnosed with hypertension had their heart sounds assessed and documented.	[2, 6]	4	7	Consensus-based recommendations	U
405	HYT	Patients newly diagnosed with hypertension had their carotid and aortic bruits assessed and documented.	[2, 6]	4	6	Consensus-based recommendations	U
406	HYT	Patients newly diagnosed with hypertension had their peripheral pulses assessed and documented.	[2, 6]	4	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
407	HYT	Patients newly diagnosed with hypertension had a neurological examination performed and documented.	[2, 6]	4	7	Consensus-based recommendations	U
408	HYT	Patients diagnosed with hypertension were advised to be on a salt reduced diet.	[2, 6]	4	7	Consensus-based recommendations	U
409	HYT	Patients diagnosed with hypertension were advised to participate in at least 30 mins per day exercise.	[2, 6]	4	7	Consensus-based recommendations	U
410	HYT	Patients diagnosed with hypertension with a BMI > 25, were advised to reduce calorie intake.	[2, 6]	4	7	Consensus-based recommendations	U
411	HYT	Patients diagnosed with hypertension had a urinalysis (for presence of albumin or protein) performed at the time of diagnosis.	[2, 6]	4	8	Consensus-based recommendations	U
412	HYT	Patients diagnosed with hypertension had their blood glucose measured at the time of diagnosis.	[2, 6]	4	8	Consensus-based recommendations	U
413	HYT	Patients diagnosed with hypertension had their electrolytes measured at the time of diagnosis.	[2, 6]	4	8	Consensus-based recommendations	U
414	HYT	Patients diagnosed with hypertension had their fasting blood lipids measured (LDL, total cholesterol) at the time of diagnosis.	[2, 6]	4	8	Consensus-based recommendations	U
415	HYT	Patients with hypertension that have documented variations in BP at the clinic had their BP monitored using self-measurement at home or ambulatory BP monitoring	[2, 6]	4	8	Consensus-based recommendations	U
416	HYT	Patients with hypertension that have suspected white coat hypertension have their BP monitored using self-measurement at home or ambulatory BP monitoring.	[2, 6]	4	8	Consensus-based recommendations	U
417	HYT	Patients with hypertension that are resistant to drug treatment have their BP monitored using self-measurement at home or ambulatory BP monitoring.	[2, 6]	4	8	Consensus-based recommendations	U
418	HYT	Patients with hypertension that have suspected hypotensive episodes have their BP monitored using self-measurement at home or ambulatory BP monitoring.	[2, 6]	4	7	Consensus-based recommendations	U
419	HYT	Patients diagnosed with hypertension and the BP is >140-159/90-99, had their BP rechecked and confirmed within 2 months.	[2, 6]	4	7	Consensus-based recommendations	U
420	HYT	Patients diagnosed with hypertension and the BP is >160-179/100-109, are reassessed or referred to a specialist within 1 month.	[2, 6]	4	6	Consensus-based recommendations	U
421	HYT	Patients diagnosed with hypertension and the BP is >= 180/110, are reassessed or referred to a specialist within 7 days.	[2, 6]	4	6	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
422	HYT	Patients with suspected or diagnosed secondary hypertension were referred to a specialist within 3 months.	[2, 6]	4	8	Consensus-based recommendations	U
423	HYT	Patients with hypertension and at high risk (diabetes, previous stroke/CVA or chronic kidney disease) of developing coronary heart disease are prescribed anti-hypertensive therapy.	[2, 6]	4	7	Consensus-based recommendations	U
424	HYT	Patients with hypertension and isolated BP SBP>=160 and DBP<70 or with widening pulse pressure are prescribed anti-hypertensive therapy.	[2, 6]	4	7	Consensus-based recommendations	U
425	HYT	Patients with hypertension and end organ failure are prescribed anti-hypertensive therapy.	[2, 6]	4	7	Consensus-based recommendations	U
426	HYT	ATSI Patients with hypertension are prescribed anti-hypertensive therapy.	[2, 6]	4	6	Consensus-based recommendations	U
427	HYT	Patients with uncomplicated hypertension are prescribed at least one of the following: • Angiotensin-converting enzyme (ACE) inhibitors (or angiotensin II receptor antagonists); • Calcium channel blocker; • Thiazide diuretics.	[2, 6]	4	8	Consensus-based recommendations	U
428	HYT	Patients on antihypertensive therapy with proteinuria >1 g/day (with or without diabetes) have their BP maintained at < 125/75.	[2, 6]	4	6	Consensus-based recommendations	U
429	HYT	Patients on antihypertensive therapy with any of the following conditions(coronary heart disease, diabetes, chronic kidney disease proteinuria[>300mg/day] or stroke/TIA) have their BP maintained at <130/80.	[2, 6]	4	7	Consensus-based recommendations	U
430	HYT	Patients on antihypertensive therapy and no other associated conditions, have their BP maintained at <140/90 (lower if tolerated).	[2, 6]	4	7	Consensus-based recommendations	U
431	HYT	Patients prescribed an antihypertensive drug have the following combination of medications avoided - ACE inhibitor (or angiotensin II receptor antagonist) plus potassium-sparing diuretic.	[2, 6]	4	7	Consensus-based recommendations	U
432	HYT	Patients prescribed an antihypertensive drug have the following combination of medications avoided - beta-blocker plus verapamil.	[2, 6]	4	8	Consensus-based recommendations	U
433	HYT	Patients with hypertension receiving antihypertensive medication have less than 4 classes of antihypertensive medications prescribed to achieve target BP.	[2, 6]	4	5	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
434	HYT	Patients with hypertension that are commenced on a new antihypertensive therapy, had it trialled for at least 6 weeks.	[2, 6]	4	6	Consensus-based recommendations	U
435	HYT	Patients with hypertension that are on maximal doses of two antihypertensive and their BP remains elevated(>140/90) were assessed for undiagnosed secondary hypertension.	[2, 6]	4	8	Consensus-based recommendations	U
436	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) were assessed for hypertensive effects of other drugs.	[2, 6]	4	7	Consensus-based recommendations	U
437	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) were assessed for treatment resistance due to sleep apnoea.	[2, 6]	4	7	Consensus-based recommendations	U
438	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) were assessed for alcohol intake or use of recreational drugs.	[2, 6]	4	7	Consensus-based recommendations	U
439	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) were assessed for unrecognised high salt intake (particularly in patients taking ACE inhibitors or angiotensin II receptor antagonists).	[2, 6]	4	7	Consensus-based recommendations	U
440	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) were assessed for "white coat" hypertension.	[2, 6]	4	7	Consensus-based recommendations	U
441	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) were assessed for volume overload, especially with chronic kidney disease.	[2, 6]	4	7	Consensus-based recommendations	U
442	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) had a review of their antihypertensive medication.	[2, 6]	4	7	Consensus-based recommendations	U
443	HYT	Patients with hypertension that are on maximal doses of two antihypertensives and their BP remains elevated(>140/90) had repeat education regarding diet and exercise.	[2, 6]	4	5	Consensus-based recommendations	U
444	HYL	Patients with hyperlipidemia had their fasting blood lipids checked and documented prior to the commencement of treatment (at least 2 measurement in preceding 12 months).	[2, 7]	5	6	Level IV	O

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
445	HYL	Patients with hyperlipidemia had their fasting blood lipids checked and documented within 4 months of hyperlipidemia medication being changed.	[2, 7]	5	6	Consensus-based recommendations	U
446	HYL	Patients with hyperlipidemia aged > 75 years with a new diagnosis of coronary heart disease had their fasting blood lipids checked and documented within 6 weeks of diagnosis of CAD.	[2, 7]	5	8	Consensus-based recommendations	U
447	HYL	Patients with elevated lipids, that are at risk of coronary heart disease were commenced on a dietary plan and/or statin therapy and had their levels re-checked within 6 weeks.	[2, 7]	5	5	Consensus-based recommendations	U
448	HYL	Patients newly diagnosed with hyperlipidemia whose plasma triglyceride levels are >2.0mmol/L are advised to limit their alcohol intake.	[2, 7]	5	7	Level IV	U
449	HYL	Patients newly diagnosed with hyperlipidemia received dietary advice.	[2, 7]	5	8	Consensus-based recommendations	U
450	HYL	Patients newly diagnosed with hyperlipidemia are asked about their smoking status and advised to quit if current smoker.	[2, 7]	5	9	Consensus-based recommendations	U
451	HYL	Patients newly diagnosed with hyperlipidemia have their BMI and waist circumference measured.	[2, 7]	5	8	Level III-4	U
452	HYL	Patients newly diagnosed with hyperlipidemia are encouraged to commence an exercise regime if appropriate (30mins moderate intensity daily as tolerated).	[2, 7]	5	8	Level III-4	U
453	HYL	Patients with hyperlipidemia are reviewed for adherence to medication at each visit.	[2, 7]	5	8	Level IV	U
454	HYL	Patients with hyperlipidemia that also have coronary heart disease are commenced on lipid modifying medication, unless contraindicated.	[2, 7]	5	9	Level II	U
455	HYL	Patients with hyperlipidemia and CAD aged >75yrs who have a LDL result >2.5mmol/L are commenced on diet and medication management within 3 months.	[2, 7]	5	6	Consensus-based recommendations	U
456	HYL	Patients with hyperlipidemia and CAD aged <75yrs who have a LDL result >2.5mmol/L, that have already been on a 6 month dietary plan are commenced on lipid modifying medication within 2 months.	[2, 7]	5	5	Consensus-based recommendations	U
457	HYL	Patients with hyperlipidemia commenced on HMG-CoA reductase inhibitor therapy had liver function tests performed within 6 weeks of commencing medication.	[2, 7]	5	7	Level IV	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
458	HYL	Patients with hyperlipidemia commenced on HMG-CoA reductase inhibitor therapy and fibrate had liver function and CK enzymes performed within 6 weeks of commencing medication.	[2, 7]	5	7	Level IV	U
459	LBP	Patients presenting with low back pain have their medical history documented at presentation.	[2]	3	9	Consensus-based recommendations	U
460	LBP	Patients presenting with low back pain have a physical examination performed and documented at presentation.	[2]	3	9	Consensus-based recommendations	U
461	LBP	Patients presenting with low back pain have been asked about/assessed for spine fractures (trauma, history of previous fracture, prolonged use of steroids).	[2]	3	9	Consensus-based recommendations	U
462	LBP	Patients presenting with low back pain have been asked about/assessed for cancer (history of cancer, unexplained weight loss, immunosuppression).	[2]	3	9	Consensus-based recommendations	U
463	LBP	Patients presenting with low back pain have been asked about/assessed for infection (fever, IV drug use).	[2]	3	9	Consensus-based recommendations	U
464	LBP	Patients presenting with low back pain had a neurological examination performed - (strength, sensation and reflexes in lower limbs).	[2]	3	9	Consensus-based recommendations	U
465	LBP	Patients presenting with low back pain have been asked about/assessed for Cauda equina syndrome which involves one of the following: • Acute onset of urinary retention; • Overflow incontinence; • Loss of anal sphincter tone; • Faecal incontinence; • Saddle anaesthesia.	[2]	3	8	Consensus-based recommendations	U
466	LBP	Patients with acute low back pain were NOT prescribed any of the following medications: • Dexamethasone; • Other oral steroids; • Colchicine; • Antidepressants.	[2]	3	8	Consensus-based recommendations	O
467	LBP	Patients with acute low back pain DID NOT receive any of the following treatments: • Transcutaneous electrical nerve stimulation (TENS); • Lumbar corsets and support belts; • Spinal traction.	[2]	3	7	Consensus-based recommendations	O

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
468	LBP	Patients with acute low back pain were NOT advised to rest in bed.	[2]	3	6	Consensus-based recommendations	O
469	OB[$]	Patients who are being assessed for obesity should have their BMI and waist circumference measured at least once in 2 years.	[21]	1	8	Level I Grade A	U
470	OB[$]	Patients who are overweight (BMI > 25) or obese (BMI>30) and aged > 40 years had their blood pressure measured at least once in 2 years.	[21]	1	6	Consensus-based recommendations	U
471	OB[$]	Patients who are overweight (BMI > 25) or obese (BMI>30) and aged > 40 years had fasting blood Lipids (Triglycerides, LDL, HDL, Total Cholesterol) measured at least once in 2 years.	[21]	1	6	Consensus-based recommendations	U
472	OB[$]	Patients who are overweight (BMI > 25) or obese (BMI>30) and aged > 40 years had a risk assessment for diabetes (AUSDRISK tool) at least once in 2 years.	[21]	1	A[¥]	Consensus-based recommendations	U
473	OB[$]	Patients diagnosed with obesity had their treatment goals and strategies documented in the medical record.	[21]	1	7	Consensus-based recommendations	U
474	OB[$]	Patients with a BMI >30 or a BMI between 26 and 29 with other risk factors were referred for dietary and physical activity advice.	[21]	1	O[#]	Consensus-based recommendations	U
475	OB[$]	Patients that are overweight (BMI > 25) with disordered eating patterns or cognitions were referred to a specialist (psychologist, nutritionist, dietician) for behaviour modification.	[21]	1	O[#]	Consensus-based recommendations	U
476	OB[$]	Patients with a BMI > 35 were referred for surgical intervention.	[21]	1	A[¥]	Consensus-based recommendations	U
477	OB[$]	Patients that are overweight (BMI > 25) or obese (BMI > 30) self-monitor their weight at home and have their progress recorded at each visit.	[21]	1	8	Consensus-based recommendations	U
478	OA	Patients with symptoms of osteoarthritis had the location of OA symptoms documented at least once in two years.	[2]	3	5	Consensus-based recommendations	U
479	OA	Patients with symptoms of osteoarthritis had an assessment for worsening or progression of OA symptoms documented at least once in two years.	[2]	3	A[¥]	Consensus-based recommendations	U
480	OA	Patients with symptoms of osteoarthritis had an assessment for the effect of OA symptoms on activities of daily living documented at least once in two years.	[2]	3	8	Consensus-based recommendations	U
481	OA	Patients with a new diagnosis of OA who have joint symptoms (pain/swelling) were advised to trial paracetamol (maximum 4g/day).	[2, 22-24]	3	8	Grade A	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
482	OA	Patients with OA of the hip/knee, who have joint symptoms have been advised to commence an exercise program.	[2, 22-24]	3	6	Grade B	U
483	OA	Patients with OA of the hip/knee, who have joint symptoms have been advised to mobilise their joints as much as possible/tolerated.	[2]	3	7	Consensus-based recommendations	U
484	OA	Patients with OA of the knee, who have joint symptoms and are obese (BMI>=30kg/m²) have been advised to commence a weight reduction program.	[21-23]	1[##]	O[#]	Grade B	U
485	OA	Patients with moderate to severe pain associated with OA were treated with Intra-articular corticosteroid injections as an adjunct to current treatment.	[21,22]	1[##]	O[#]	Grade B	U
486	OA	Patients with moderate to severe pain associated with OA of the knee were treated with Intra-articular hyaluronic acid injections as an adjunct to current treatment.	[21]	1[##]	O[#]	Grade C	U
487	OA	Patients with OA that have specific problems with activities of daily living were assessed for the use of assistive devices (e.g. walking sticks, tap turners).	[22,23]	1[##]	O[#]	Consensus-based recommendations	U
488	OA	Patients with OA have had the use of transcutaneous electrical nerve stimulation (TENS) discussed as an adjunct to core treatment.	[21, 22]	1[##]	O[#]	Grade C	U
489	OA	Patients with OA have had the use of local heat or cold therapy discussed as an adjunct to core treatment.	[21, 22]	1[##]	O[#]	Grade C	U
490	OA	Patients with knee or hand OA have had the use of topical NSAIDs discussed as an adjunct to paracetamol.	[21, 22]	1[##]	O[#]	Grade C	U
491	OA	Patients with OA had documented evidence of the use of topical NSAIDs and/or paracetamol prior to the use of oral NSAIDs, COX-2 inhibitors or opioids..	[21-23]	1[##]	O[#]	Grade B	U
492	OA	Patients with severe symptomatic knee or hip OA, which impacts on their quality of life (following a period of non-surgical management) has a referral for joint replacement surgery.	[21, 22]	1[##]	O[#]	Consensus-based recommendations	U
493	OA	For patients with OA, where simple analgesia and non-pharmacological measures were ineffective, NSAIDs or COX-2 NSAIDs were prescribed for short term treatment only.	[21, 22]	1[##]	O[#]	Grade B	U
494	OA	Patients with OA prescribed NSAIDS or COX - 2 NSAIDS, who are at an increased risk of side effects (age > 65, or on concomitant medication) had their blood pressured and renal function monitored.	[21-23]	1[##]	O[#]	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
495	OA	Patients with OA prescribed NSAIDS or COX - 2 NSAIDS considered to be high risk were also prescribed a proton pump inhibitor (PPI) or COX-2 inhibitor.	[21-23]	1[##]	O[#]	Consensus-based recommendations	U
496	OA	Patients with at least moderate or severe pain associated with OA, that did not respond to, or are unable to tolerate other analgesic medications or NSAIDs, and joint replacement surgery is contraindicated or delayed, had opioids prescribed.	[21,22]	1[##]	O[#]	Grade A	U
497	OA	Patients with severe symptomatic knee or hip OA, were referred to an orthopaedic surgeon.	[21, 22]	1[##]	O[#]	Consensus-based recommendations	U
498	OA	Patients with OA who were referred to an orthopaedic surgeon, were referred before the patient suffered prolonged and established functional limitation and severe pain.	[22, 23]	1[##]	O[#]	Consensus-based recommendations	U
499	OP	Patients with a new diagnosis of osteoporosis have dietary calcium intake discussed and documented.	[3, 25]	4	8	Consensus-based recommendations	U
500	OP	Patients with a new diagnosis of osteoporosis have dietary vitamin D intake discussed and documented.	[3, 25]	4	7	Consensus-based recommendations	U
501	OP	Patients with a new diagnosis of osteoporosis have documented evidence that there has been a discussion regarding weight bearing exercises in the medical record.	[3, 25]		6	Consensus-based recommendations	U
502	OP	Patients with a new diagnosis of osteoporosis have been advised to stop smoking and advised to stop if current smoker (quit-line supplied).	[3, 25]	4	8	Consensus-based recommendations	U
503	OP	Patients with a new diagnosis of osteoporosis had their caffeine intake assessed at the time of diagnosis.	[3, 25]	4	5	Consensus-based recommendations	U
504	OP	Patients with a new diagnosis of osteoporosis had their alcohol intake assessed at the time of diagnosis.	[3, 25]	4	7	Consensus-based recommendations	U
505	OP	Patients with a new diagnosis of osteoporosis that have excessive intake of caffeine and/or alcohol were advised to limit their intake.	[3, 25]	4	7	Consensus-based recommendations	U
506	OP	Patients with a new diagnosis of osteoporosis received counselling on falls prevention.	[3, 25]	4	6	Consensus-based recommendations	U
507	OP	Patients with a new diagnosis of osteoporosis are asked if they are on any of the following medications as a potential cause: • Oral glucocorticosteroids (prednisone); • Long term heparin; • Antiepileptic (phenytoin); • Androgen deprivation therapy for prostate cancer;	[3, 25]	4	7	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)[+]	Level of evidence	U/O**
		• Aromatase inhibitors for breast cancer; • Thiazolidines for diabetes.					
508	OP	Patients who have had an osteoporotic fracture that are ambulatory have been offered a physical activity/exercise program within 3 months of fracture diagnosis.	[3, 25]	4	8	Consensus-based recommendations	U
509	PD	Patients with symptoms of panic disorder are involved in shared decision making.	[26]	3	6	Consensus-based recommendations	U
510	PD	Patients with symptoms of panic disorder are provided with information on the nature, course and treatment of panic disorder.	[26]	3	8	Consensus-based recommendations	U
511	PD	Patients with symptoms of panic disorder are provided with information on self-help and support groups.	[26]	3	8	Consensus-based recommendations	U
512	PD	Patients with symptoms of panic disorder are informed of the side effects of medication and the issues involved with adherence to the medications.	[26]	3	8	Consensus-based recommendations	U
513	PD	Patients with symptoms of panic disorder or generalized anxiety disorder have a personal mental health history documented.	[26]	3	9	Consensus-based recommendations	U
514	PD	Patients with symptoms of panic disorder or generalized anxiety disorder have self-medication history documented.	[26]	3	8	Consensus-based recommendations	U
515	PD	Patients with symptoms of panic disorder or generalized anxiety disorder have completed one of the following short, self-complete questionnaires to monitor outcomes: • Depression, Anxiety and Stress Scales (DASS21); • Kessler Psychological Distress Scale (K10); • Fear Questionnaire; • Yale–Brown Obsessive Compulsive Scale (YBOCS); • Revised impact of events scale.	[26]	3	8	Consensus-based recommendations	U
516	PD	Patients diagnosed with panic disorder are NOT treated with benzodiazepines.	[26]	3	5	Consensus-based recommendations	O
517	PD	Patients diagnosed with panic disorder are treated with at least one of the following: • Psychological therapy (cognitive behavioural therapy); • Pharmacological therapy (Selective serotonin re-uptake inhibitors (SSRI), imipramine, clomipramine, Serotonin–norepinephrine reuptake inhibitors	[26]	3	8	Consensus-based recommendations	U

No	Condition	Indicator	Source	No. of reviewers	Mean score (1-9)$^+$	Level of evidence	U/O**
		(SNRI)); • Self-help (bibliotherapy - written material on CBT, attend self-help group).					
518	PD	Patients diagnosed with generalized anxiety disorder that were prescribed benzodiazepines (diazepam, oxazepam, alprazolam), did not receive them for longer than 4 weeks.	[26]	3	7	Consensus-based recommendations	U
519	PD	Patients diagnosed with generalized anxiety disorder are treated with at least one of the following: • Psychological therapy (cognitive behavioural therapy); • Pharmacological therapy (SSRI, imipraminea, clomipraminea, SNRI); • Self-help (bibliotherapy - written material on CBT).	[26]	3	8	Consensus-based recommendations	U
520	PD	Patients with panic or generalized anxiety disorder were referred to a mental health service if any 2 of the following (alone or in combination) have failed: • Psychological therapy; • Medication; • Self – help.	[26]	3	6	Consensus-based recommendations	U
521	PD	Patients that presented with a panic attack had a follow-up appointment arranged within 3 weeks.	[26]	3	7	Consensus-based recommendations	U
522	PD	Patients that presented with a panic attack received written information about support or self-help groups.	[26]	3	9	Consensus-based recommendations	U

$^+$Scoring guidelines for clinical indicators: 7-9 = very appropriate; 4-6 = appropriate; 1-3 = not appropriate

** O = Overuse; U = Underuse.

O$^#$ = Indicator was not sent to expert or did not receive a score.

A$^¥$ = Indicator was added to the condition following recommendation of inclusion by expert reviewers.

$^{##}$ - Reviewed by one expert only (component of PhD project)

$ *Obesity, community acquired pneumonia*, and *antibiotic use* received < three expert reviews and review was completed by the clinical authors.

Definitions of Levels of Evidence

Consensus based recommendations include those agreed to by expert reviewers and/or those identified as a Good Practice Point in the relevant guideline document. Definitions for levels of evidence or grades of recommendations are derived from the National Health and Medical Research Council (NHMRC) [27]. The levels of evidence and grades of recommendation provided in Table 2 are taken directly from the source document from which the indicator was obtained. Source documents were inconsistent in assigning levels of evidence and /or grades of recommendations. A level of evidence is assigned based on the type of research question, whilst a grade of recommendation is provided based on the body of evidence as a whole and indicates the strength of a recommendation. This resulted in some indicators having both a level of evidence and a grade of recommendation, or just a level or a recommendation assigned. Tables 3 and 4 provide the NHMRC definitions for both levels of evidence and grades of recommendations [27].

Table 3: Designations of levels of evidence according to type of research question [27].

Level	Intervention	Diagnosis	Prognosis	Aetiology	Screening
I	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies	A systematic review of level II studies
II	A randomised control trial	A study of test accuracy with: an independent, blinded comparison with a valid reference standard, among non-consecutive patients with a defined clinical presentation	All or none	All or none	A pseudo randomised controlled trial (i.e. alternate allocation or some other method)
III-1	A pseudo randomised controlled trial (i.e. alternate allocation or some other method)	A comparison with reference standard that does not meet the criteria required for Level II and III-1 evidence	Analysis of prognostic factors amongst untreated control patients in a randomised controlled trial	A retrospective cohort study	A comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case-control study

III-2	A comparative study with concurrent controls: • Non randomised, experimental trial • Cohort study • Case-control study • Interrupted time series with a control group.	standard that does not meet the criteria required for Level II and III-1 evidence	Analysis of prognostic factors amongst untreated control patients in a randomised controlled trial	A retrospective cohort study	A comparative study with concurrent controls: • Non-randomised, experimental trial • Cohort study • Case-control study
III-3	A comparative study without concurrent controls: • Historical control study • Two or more single arm study • Interrupted time series without a parallel control group	Diagnostic case-control study	A retrospective cohort study	A case-control study	A comparative study without concurrent controls: • Historical control study • Two or more single arm study
IV	Case series with either post-test or pre-test/post-test outcomes	Study of diagnostic yield (no reference standard)	Case series, or cohort study of patients at different stages of disease	A cross-sectional study	Case series

Table 4: NHMRC Grades of recommendations [27].

Grade of recommendation	Description
A	Body of evidence can be trusted to guide practice
B	Body of evidence can be trusted to guide practice in most situations
C	Body of evidence provides some support for recommendation(s) but care should be taken in its application
D	Body of evidence is weak and recommendation must be applied with caution

Definitions for at risk individuals with a family history of Colo-rectal cancer

Category 1 — those at or slightly above average risk (related to Indicators no.s 10 &11)
Asymptomatic people fit into this category if they have:

- no personal history of bowel cancer, advanced adenoma, or chronic ulcerative colitis, and

- either no close relatives with bowel cancer or one first-degree or second-degree relative with bowel cancer diagnosed at age 55 years or older.

Category 2 — those at moderately increased risk (related to Indicators no. 12)
Asymptomatic people fit into this category if they have:

- one first-degree relative with bowel cancer diagnosed before the age of 55 years (without the potentially high-risk features listed below), or

- two first-degree *or* one first- and one second-degree relative(s) on the same side of the family with bowel cancer diagnosed at any age (without the potentially high-risk features listed below).

Category 3 — those at potentially high risk (related to Indicators no.s 13, 14, 15)
Asymptomatic people fit into this category if they have:

- three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected HNPCC), or

- two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:
  – multiple bowel cancers in the one person
  – bowel cancer before the age of 50 years

47

– at least one relative with cancer of the endometrium, ovary, stomach, small bowel, renal pelvis, ureter, biliary tract or brain (suspected HNPCC, see Chapter 7)

• at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected FAP) or

• somebody in the family in whom the presence of a high-risk mutation in the APC (adenomatous polyposis coli) gene or one of the mismatch repair (MMR) genes has been identified.

Definitions for Asthma

Moderate persistent asthma (related to Indicators no.s 94-98)

Untreated asthma is classified as moderate persistent if **one or more** of the following applies (and more severe signs and symptoms are **not** present):

• Daytime asthma symptoms occur every day, but do not generally restrict physical activity.

• Night-time asthma symptoms occur at least once per week.

• Exacerbations occur occasionally and may affect activity or sleep.

• FEV1 is 60–80% predicted and varies by more than 30%.

Severe persistent asthma (related to Indicators no.s 94-98)

Untreated asthma is classified as severe persistent if **one or more** of the following applies:

• Daytime asthma symptoms occur every day and restrict physical activity.

• Night-time asthma symptoms occur every day.

• Exacerbations are frequent.

• FEV1 is 60% predicted or less, and varies by more than 30%.

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