

SSNAP

**Sentinel Stroke National
Audit Programme**



KING'S
College
LONDON

SSNAP Core Dataset 5.0.0 for Teams in Northern Ireland

For queries, please contact ssnap@kcl.ac.uk
Webtool for data entry: www.strokeaudit.org

A log of changes made to the SSNAP Core Dataset can be found on page 16 of this document, [available here](#).

The only difference in the dataset for teams in Northern Ireland is that patient identifiable information cannot be entered onto the webtool. This is due to the different legal requirements for Northern Ireland. We will alert all participants in Northern Ireland if the situation changes and patient identifiable information becomes permissible to enter, but this is most likely to occur on a trust-by-trust basis.

Teams in Northern Ireland are encouraged to keep note of the patient identifiable information alongside the patient audit number (assigned by the webtool when a new record is created) within their trust, so that it is easier to refer back to patient notes if necessary.

Hospital / Team

Auto-completed on web tool

Patient Audit Number

Auto-completed on web tool

Demographics/ Onset/ Arrival (must be completed by the first hospital)

1.1. Hospital Number (**not available to answer on webtool for teams in Northern Ireland**)

Free text (30 character limit)

1.2. NHS Number (**not available to answer on webtool for teams in Northern Ireland**)

10 character numeric

or No NHS Number

1.3. Surname (**not available to answer on webtool for teams in Northern Ireland**)

Free text (30 character limit)

1.4. Forename (**not available to answer on webtool for teams in Northern Ireland**)

Free text (30 character limit)

1.5. Date of birth (**not available to answer on webtool for teams in Northern Ireland**)

dd mm yyyy

Age on arrival (**teams in Northern Ireland must put age on arrival instead**)

16-120

1.6. Gender Male Female

1.7. Postcode of usual address (**teams in Northern Ireland can only put the first portion of the postcode on the webtool**)

2-4 alphanumerics

1.8. Ethnicity A – Z (select radio button) or Not Known

1.9. What was the diagnosis? Stroke TIA Other (If TIA or Other please go to relevant section)

1.10. Was the patient already an inpatient at the time of stroke? Yes No

1.11. Date/time of onset/awareness of symptoms dd mm yyyy hh mm

1.11.1. The date given is: Precise Best estimate Stroke during sleep

1.11.2. The time given is: Precise Best estimate Not known

1.12. Did the patient arrive by ambulance? Yes No

If yes:

1.12.1. Ambulance trust Default Drop-down of all trusts

1.12.2. Computer Aided Despatch (CAD) / Incident Number 10 characters

1.13. Date/ time patient arrived at first hospital dd mm yyyy hh mm

1.14. Which was the first ward the patient was admitted to at the first hospital?
MAU/ AAU/ CDU Stroke Unit ITU/CCU/HDU Other

1.15. Date/time patient first arrived on a stroke unit or Did not stay on stroke unit
dd mm yyyy hh mm

Casemix/ First 24 hours (if patient is transferred to another setting after 24 hours, this section must be complete)

2.1. Did the patient have any of the following co-morbidities prior to this admission?

- 2.1.1a Congestive Heart Failure: Yes No
- 2.1.1b Hypertension: Yes No
- 2.1.1c Atrial fibrillation: Yes No
- 2.1.1d Diabetes: Yes No
- 2.1.1e Stroke/TIA: Yes No
- 2.1.1f Dementia: Yes No

2.1.6 If 2.1.1c is yes, was the patient on antiplatelet medication prior to admission? Yes No No but

2.1.7 Was the patient on anticoagulant medication prior to admission? Yes No No but

2.1.7(a) What anticoagulant was the patient prescribed before their stroke?

Vitamin K antagonists (includes Warfarin)

DOAC

Heparin

2.1.7(b) What was the patient's International Normalised ratio (INR) on arrival at hospital (if inpatient, INR at the time of stroke onset)?

Allowable values (0.0 – 10.0) [0.0]

INR not checked

Greater than 10

2.1.8 Was a new diagnosis of AF made on admission?

Yes No

2.2. What was the patient's modified Rankin Scale score before this stroke?

0 - 5

2.3. What was the patient's NIHSS score on arrival?

Automated calculation of total score

		0	1	2	3	4	Not known
2.3.1	Level of Consciousness (LOC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2.3.2	LOC Questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.3	LOC Commands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.4	Best Gaze	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.5	Visual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.3.6	Facial Palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.3.7	Motor Arm (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.8	Motor Arm (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.9	Motor Leg (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.10	Motor Leg (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.3.11	Limb Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.12	Sensory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.13	Best Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.3.14	Dysarthria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.3.15	Extinction and Inattention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>

2.4. Date and time of first brain imaging after stroke or Not imaged

dd

mm

yyyy

hh

mm

2.4.1. Modality of first brain imaging after stroke:

Plain/non-contrast CT

- CT Intracranial angiogram
- CT Perfusion
- Plain/non-contrast MRI
- Contrast-enhanced MRA
- MR Perfusion

2.4.2. Was artificial intelligence (AI) used to support the interpretation of the first brain imaging?
Yes No

2.5. What was the type of stroke? Infarction Primary Intracerebral Haemorrhage

2.6. Was the patient given thrombolysis? Yes No No but (auto-selected if 2.5=PIH)

2.6.1 If no, what was the reason:

- Thrombolysis not available at hospital at all Outside thrombolysis service hours
- Unable to scan quickly enough None

2.6.2 If no but, please select the reasons:

- Haemorrhagic stroke (auto-selected if 2.5=PIH) Age
- Arrived outside thrombolysis time window Symptoms improving
- Co-morbidity Stroke too mild or too severe
- Contraindicated medication Symptom onset time unknown/wake-up stroke
- Patient or relative refusal Other medical reason

2.7. Date and time patient was thrombolysed

2.8. Was there evidence of cerebral haemorrhage on brain imaging after the patient received thrombolysis/thrombectomy?
Yes No

2.9. What was the patient's NIHSS score at 24 hours after thrombolysis / intra-arterial intervention?

		0	1	2	3	4	Not known
2.9.1	Level of Consciousness (LOC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2.9.2	LOC Questions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.3	LOC Commands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.4	Best Gaze	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.5	Visual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.9.6	Facial Palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.9.7	Motor Arm (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.8	Motor Arm (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.9	Motor Leg (left)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.10	Motor Leg (right)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.9.11	Limb Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.12	Sensory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.13	Best Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
2.9.14	Dysarthria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
2.9.15	Extinction and Inattention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>

2.10. Date and time of first swallow screen
or Patient not screened in first 4 hours

2.10.1 If screening was not performed within 4 hours, what was the reason?

2.11.0 Was patient referred for intra-arterial intervention for acute stroke?

- Yes, accepted at this team
- Yes, accepted at another team
- Yes, but declined

Not referred

2.11.0a Date and time of initial referral for intra-arterial intervention

2.11.0b Date and time ambulance transfer requested

2.11.0c Date and time ambulance departed referring hospital

2.11.0d Was a helicopter used? Yes No

2.11 Did the patient receive an intra-arterial intervention for acute stroke? Yes No

2.11a If no, reason a procedure (arterial puncture) not begun:

Pre-procedure imaging demonstrated reperfusion – procedure not required

Pre-procedure imaging demonstrated the absence of salvageable brain tissue

Other reason

2.11.1 Was the patient enrolled into a clinical trial of intra-arterial intervention? Yes No

2.11.2 What brain imaging technique(s) was carried out prior to the intra-arterial intervention?

a. CTA or MRA Yes No

b. Measurement of ASPECTS score Yes No

c. Assessment of ischaemic penumbra by perfusion imaging Yes No

i. Was the perfusion CT MR Both

2.11.3 How was anaesthesia managed during the intra-arterial intervention?

Local anaesthetic only (anaesthetist NOT present)

Local anaesthetic only (anaesthetist present)

Local anaesthetic and conscious sedation (anaesthetist NOT present)

Local anaesthetic and conscious sedation (anaesthetist present)

General anaesthetic from the outset

General anaesthetic by conversion from lesser anaesthesia

Other

2.11.3a Specialty of anaesthetist (if present):

Neuroanaesthetics

General anaesthetics

Not present

2.11.4 What was the specialty of the lead operator?

Interventional neuroradiologist

Cardiologist

Interventional radiologist

Training fellow/specialty trainee

Other

2.11.4a What was the specialty of the second operator?

Interventional neuroradiologist

Cardiologist

Interventional radiologist

Training fellow/specialty trainee

Other

No second operator

2.11.4b What intervention lab was used: Biplane Monoplane

2.11.4c If monoplane, why? Biplane in use Biplane being serviced Other

2.11.5 Which method(s) were used to reopen the culprit occlusion?

- a. Thrombo-aspiration system Yes No
- b. Stent retriever Yes No
- c. Proximal balloon/flow arrest guide catheter Yes No
- d. Distal access catheter Yes No

2.11.6 Date and time of:

a. Arterial puncture:

b. First deployment of device for thrombectomy or aspiration

Not performed

i. Deployment of device not performed because:

- Unable to obtain arterial access
- Procedure begun but unable to access the target intracranial vessel
- Medical condition caused the procedure to be abandoned
- Other reason

c. End of procedure (time of last angiographic run on treated vessel):

d. Were any of the following procedures required (*select all that apply*)?

- Cervical Carotid stenting Yes No
- Cervical Carotid angioplasty Yes No

e. How many passes were required?

2.11.7. Were there any procedural complications? (*select all that apply*)

- a. Distal clot migration/embolisation within the affected territory Yes No
- b. Embolisation to a new territory Yes No
- c. Intracerebral haemorrhage Yes No
- d. Subarachnoid/intraventricular haemorrhage Yes No
- e. Arterial dissection or perforation Yes No
- f. Vasospasm Yes No
- g. Other Yes No

2.11.8 Angiographic appearance of culprit vessel and result assessed by operator (modified TICI score)

- a. Pre intervention 0 1 2a 2b 2c 3
- b. Post intervention 0 1 2a 2b 2c 3

2.11.9 Where was the patient transferred after the completion of the procedure?

- Intensive care unit or high dependency unit
- Stroke unit at receiving site
- Stroke unit at referring site
- Other

a. If transferred to ICU or HDU, what was the indication for high-level care?

- Unstable blood pressure
- Airway or cardiac instability
- Bleeding at procedure site
- Failure to wake from anaesthetic
- Agitation/need for sedation
- Renal failure
- Other
- None of the above

- 2.12 What was the patient's systolic blood pressure on arrival at hospital (the first SBP taken in the hospital) (note: if onset in hospital, first systolic blood pressure after stroke onset)
[0] mmHg (range = 30-300)
- 2.13. Date/time of acute blood pressure lowering treatment, if given to the patient within 24 hours of onset? ("if onset is unknown, only answer if given within 1 day of stroke onset")
Date: [Click here to enter a date.](#) Time: 00:00 Not given
- 2.14 Date/time SBP (Systolic Blood Pressure) of 140mmHg or lower was first achieved?
Date: [Click here to enter a date.](#) Time: 00:00
 Not achieved within 24h
- 2.15. Was the patient given anticoagulant reversal therapy?
Yes No

If yes, 2.15.1. What reversal agent was given?

- PCC
- DOAC antidote
- FFP
- Protamine
- Vitamin K

- 2.15.2. Date and time reversal agent was given
Date: [Click here to enter a date.](#) Time: 00:00

Assessments – First 72 hours (if patient is transferred after 72 hours, this section must be complete and locked)

3.1. Has it been decided in the first 72 hours that the patient is for palliative care? Yes No
If yes:

3.1.1. Date of palliative care decision

3.1.2. If yes, does the patient have a plan for their end of life care? Yes No

3.2. Date/time first assessed by nurse trained in stroke management or No assessment in first 72 hours

3.3a Date/time first assessed by stroke specialist consultant physician or No assessment in first 72 hours

3.3b How was contact first made with the stroke consultant?

In person

By telephone

Telemedicine

3.3c If first contact with consultant was not in person, date and time first assessed by stroke specialist consultant physician in person

3.4. Date/time of first swallow screen (If date/time already entered for screening within 4 hours (2.10), 3.4 does not need to be answered)
or Patient not screened in first 72 hours

3.4.1 If screening was not performed within 72 hours, what was the reason?

3.5. Date/time first assessed by an Occupational Therapist or No assessment in first 72 hours

3.5.1 If assessment was not performed within 72 hours, what was the reason?

3.6. Date/time first assessed by a Physiotherapist or No assessment in first 72 hours

3.6.1 If assessment was not performed within 72 hours, what was the reason?

3.7. Date/time communication first assessed by Speech and Language Therapist or No assessment in first 72 hours

3.7.1 If assessment was not performed within 72 hours, what was the reason?

3.8. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment or No assessment in first 72 hours

3.8.1 If assessment was not performed within 72 hours, what was the reason?

3.9. It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?

Yes, patient gave consent

No, patient refused consent

Patient not asked

This admission (this section must be completed by every team/ hospital/ care setting)

4.1. Date/ time patient arrived at this hospital/team

4.2. Which was the first ward the patient was admitted to at this hospital?
 MAU/ AAU/ CDU Stroke Unit ITU/CCU/HDU Other

4.3. Date/time patient arrived on stroke unit at this hospital
 or Did not stay on stroke unit

	1. Physiotherapy	2. Occupational Therapy	3. Speech and language therapy	4. Psychology
4.4. Was the patient considered to require this therapy at any point in this admission?	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
4.4.1 If yes, at what date was the patient no longer considered to require this therapy?				
4.5. On how many days did the patient receive this therapy across their total stay in this hospital/team?				
4.6. How many minutes of this therapy in total did the patient receive during their stay in this hospital/team?				
4.6.1 How many of the total therapy minutes were provided by a rehabilitation assistant?				
4.6.2 How many of the total therapy minutes were delivered by video/teletherapy?				

4.7. Date rehabilitation goals agreed: or No goals

4.7.1. If no goals agreed, what was the reason?	
Not known <input type="radio"/>	Patient medically unwell for entire admission <input type="radio"/>
Patient refused <input type="radio"/>	Patient has no impairments <input type="radio"/>
Organisational reasons <input type="radio"/>	Patient considered to have no rehabilitation potential <input type="radio"/>

4.8. Was the patient considered to require nursing care at any point whilst under the care of this team?	Yes <input type="radio"/> No <input type="radio"/>
4.8.1 If yes, at what date was the patient no longer considered to require this care?	
4.8.2. On how many days did the patient receive nursing care across their total stay in this team?	
4.8.3. How many minutes of nursing care in total did the patient receive during their stay in this team?	

4.9 Date patient screened for mood using a validated tool or Not Screened

4.9.1 If not screened, what was the reason?

4.10 Date patient screened for cognition using a simple standardised measure?

or Not Screened

4.10.1 If not screened, what was the reason?

Patient Condition in first 7 days *(if patient is transferred after 7 days, this section must be complete)*

- 5.1. What was the patient's worst level of consciousness in the first 7 days following initial admission for stroke? (Based on patient's NIHSS Level of Consciousness (LOC) score): 0 1 2 3
- 5.2. Did the patient develop a urinary tract infection in the first 7 days following initial admission for stroke as defined by having a positive culture or clinically treated? Yes No Not known
- 5.3. Did the patient receive antibiotics for a newly acquired pneumonia in the first 7 days following initial admission for stroke? Yes No Not known

Assessments – By discharge (some questions are repeated from the “Assessments – First 72 hours” section but should only be answered if assessments not carried out in the first 72 hours)

6.1. Date/time first assessed by an Occupational Therapist
 or No assessment by discharge

6.1.1 If no assessment, what was the reason?

6.2. Date/time first assessed by a Physiotherapist
 or No assessment by discharge

6.2.1 If no assessment, what was the reason?

6.3. Date/time communication first assessed by Speech and Language Therapist
 or No assessment by discharge

6.3.1 If no assessment, what was the reason?

6.4. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment
 or No assessment by discharge

6.4.1 If no assessment, what was the reason?

6.5. Date urinary continence plan drawn up or No plan

6.5.1 If no plan, what was the reason?

6.6. Was the patient identified as being at high risk of malnutrition following nutritional screening?
 Yes No Not screened

6.6.1 If yes, date patient saw a dietitian or Not seen by a dietitian

6.7. Date patient screened for mood using a validated tool or Not screened

6.7.1 If not screened, what was the reason?

6.8. Date patient screened for cognition using a simple standardised measure?
 or Not screened

6.8.1 If not screened, what was the reason?

6.9. Has it been decided by discharge that the patient is for palliative care? Yes No
 If yes:

6.9.1 Date of palliative care decision

6.9.2 If yes, does the patient have a plan for their end of life care? Yes No

6.10. First date rehabilitation goals agreed: or No goals

This question is auto-completed. It will be based on the first date that is entered for 4.7. If no hospitals / care settings in the pathway enter a date (i.e. all select ‘no goals’), then ‘no goals’ will be selected here

6.11. Was intermittent pneumatic compression applied? Yes No Not Known

6.11.1 If yes, what date was intermittent pneumatic compression first applied?

6.11.2 If yes, what date was intermittent pneumatic compression finally removed?

Discharge / Transfer

- 7.1. The patient:
Died
Was discharged to a care home
Was discharged home
Was discharged to somewhere else
Was transferred to another inpatient care team
Was transferred to an ESD / community team
Was transferred to another inpatient care team, not participating in SSNAP
Was transferred to an ESD/community team, not participating in SSNAP
- 7.1.1 If patient died, what was the date of death?
- 7.1.2 Did the patient die in a stroke unit? Yes No
- 7.1.3 What hospital/team was the patient transferred to?
- 7.2. Date/time of discharge from stroke unit
- 7.3. Date/time of discharge/transfer from team
- 7.3.1 Date patient considered by the multidisciplinary team to no longer require inpatient care?
- 7.4. Modified Rankin Scale score at discharge/transfer (defaults to 6 if 7.1 is died in hospital)
- 7.5. If discharged to a care home, was the patient: Previously a resident Not previously a resident
- 7.5.1 If not previously a resident, is the new arrangement: Temporary Permanent
- 7.6. If discharged home, is the patient: Living alone Not living alone Not known
- 7.7. Was the patient discharged with an Early Supported Discharge multidisciplinary team?
Yes, stroke/neurology specific Yes, non-specialist No
- 7.8. Was the patient discharged with a multidisciplinary community rehabilitation team?
Yes, stroke/neurology specific Yes, non-specialist No
- 7.9. Did the patient require help with activities of daily living (ADL)? Yes No
If yes:
- 7.9.1 What support did they receive?
Paid carers Paid care services unavailable
Informal carers Patient refused
Paid and informal carers
- 7.9.2 At point of discharge, how many visits per week were social services going to provide?
or Not known
- 7.10. Is there documented evidence that the patient is in atrial fibrillation on discharge? Yes No
- 7.10.1 If yes, was the patient taking anticoagulation (not anti-platelet agent) on discharge or discharged with a plan to start anticoagulation within the next month? Yes No No but
- 7.11. Is there documented evidence of joint care planning between health and social care for post discharge management? Yes No Not applicable
- 7.12. Is there documentation of a named person for the patient and/or carer to contact after discharge? Yes No

7.13 Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?
Yes No Not known/not tested

7.13.1 If Yes, was COVID-19:

Present on admission (i.e. the admission COVID test was positive)
Confirmed subsequently during the patient's stay
Confirmed after death

7.14 It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?

Yes, patient gave consent
No, patient refused consent
Patient not asked

Comprehensive Questions

Comprehensive questions are not currently required can be completed.

7.101 Barthel score at discharge

Six month (post admission) follow-up assessment

8.1. Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?
Yes No No but No, patient died within 6 months of admission
N.B. 'No but' should only be answered for DNAs, patients who are not registered with a GP, or patients who have had another stroke and a new SSNAP record started

8.1.1 What was the date of follow-up?

8.1.2 How was the follow-up carried out: In person By telephone Online By post

8.1.3 Which of the following professionals carried out the follow-up assessment:

GP District/community nurse
Stroke coordinator Voluntary Services employee
Therapist Secondary care clinician
Other

8.1.4 If other, please specify

8.1.5 Did the patient give consent for their identifiable information to be included in SSNAP?*

Yes, patient gave consent No, patient refused consent Patient was not asked

8.2 Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?

Yes No No but

8.2.1 If yes, was the patient identified as needing support? Yes No

8.2.2 If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?

Yes No No but

8.3. Where is this patient living? Home Care home Other

8.3.1 If other, please specify

8.4. What is the patient's modified Rankin Scale score?

8.5. Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes No

8.6. Is the patient taking:

8.6.1 Antiplatelet: Yes No

8.6.2 Anticoagulant: Yes No

8.6.3 Lipid Lowering: Yes No

8.6.4 Antihypertensive: Yes No

8.7. Since their initial stroke, has the patient had any of the following:

8.7.1 Stroke Yes No

8.7.2 Myocardial infarction Yes No

8.7.3 Other illness requiring hospitalisation Yes No

8.8. Employment status prior to stroke:

Working full-time

Working part-time

Retired

Studying or Training

Unemployed

Other

8.8.1. Employment status currently:

Working full-time

Working part-time

Retired

- Studying or Training
- Unemployed
- Other

8.9. EQ5D-5L score six months after stroke:

- a. Mobility (1-5, 9 if missing)
- b. Self-Care (1-5, 9 if missing)
- c. Usual activities (work, study, etc.) (1-5, 9 if missing)
- d. Pain/discomfort (1-5, 9 if missing)
- e. Anxiety/Depression (1-5, 9 if missing)
- f. How is your health today? (1-100, 999 if missing)

*8.1.5. This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board.

Changes to the SSNAP Core Dataset

Version	Date	Changes
NI 1.1.1	12 Dec 2012	<ul style="list-style-type: none"> – Official core dataset following pilot versions (most recent 3.6.16)
NI 2.1.1	04 Apr 2014	<ul style="list-style-type: none"> – 1.14 Which was the first ward the patient was admitted to at the first hospital? (wording change from ‘Which was the first ward the patient was admitted to?’) – 3.1 Has it been decided in the first 72 hours that the patient is for palliative care? (wording change from ‘If yes, does the patient have a plan for their end of life care?’) – 3.1.2 – If yes, does the patient have a plan for their end of life care? (wording change from ‘Is the patient on an end of life pathway?’) – 4.4.1 – New question: ‘If yes, at what date was the patient no longer considered to require this therapy?’ – 4.5.1 Question removed – 4.6.1 Question removed – 6.9.2 – If yes, does the patient have a plan for their end of life care? (wording change from ‘Is the patient on an end of life pathway?’) – 6.11 - New question: ‘Was intermittent pneumatic compression applied?’ – 6.11.1 - New question: ‘If yes, what date was intermittent pneumatic compression first applied?’ <i>Validations: Cannot be before clock start and cannot be after 7.3</i> – 6.11.2 - New question: ‘If yes, what date was intermittent pneumatic compression finally removed?’ <i>Cannot be before clock start or 6.11.1 and cannot be after 7.3</i> – 7.1 – Additional answer options: ‘Was transferred to another inpatient care team, not participating in SSNAP’; ‘Was transferred to an ESD/community team, not participating in SSNAP’. <i>Validations: Selecting either of these has same effect as selecting ‘discharged somewhere else’</i> – 7.3.1 – ‘Date patient considered by the multidisciplinary team to no longer require inpatient care?’ (wording change from ‘Date patient considered by the multidisciplinary team to no longer require inpatient rehabilitation?’) – 8.4 – Additional answer option: ‘Not Known’. (‘What is the patient’s modified Rankin Scale score?’) – 8.5 – Additional answer option: ‘Not Known’. (‘Is the patient in persistent, permanent or paroxysmal atrial fibrillation?’) – 8.6.1 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Antiplatelet?’) – 8.6.2 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Anticoagulant?’) – 8.6.3 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Lipid Lowering?’) – 8.6.4 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Antihypertensive?’) – 8.7.1 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Stroke’) – 8.7.2 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Myocardial infarction’) – 8.7.3 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Other illness requiring hospitalisation’)
NI 3.1.1	01 Oct 2015	<ul style="list-style-type: none"> – 2.11 – New question – ‘Did the patient receive an intra-arterial intervention for acute stroke?’ – 2.11.1 – New question – ‘Was the patient enrolled into a clinical trial of intra-arterial intervention?’ – 2.11.2 – New question – ‘What brain imaging technique was carried out prior to the intra-arterial intervention?’ – 2.11.3 – New question – ‘How was anaesthesia managed during the intra-arterial intervention?’ – 2.11.4 – New question – ‘What was the speciality of the lead operator?’ – 2.11.5 – New question – ‘Were any of the following used?’ – 2.11.6 – New question – ‘Date and time of:’ – 2.11.7 – New question – ‘Did any of the following complications occur?’ – 2.11.8 – New question – ‘Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):’ – 2.11.9 – New question – ‘Where was the patient transferred after the completion of the procedure?’
NI 4.0.0	07 Decemb er 2020	<p>Delayed from 01 December 2017:</p> <ul style="list-style-type: none"> – 2.1.7 - remove validation: Validation Change: “Yes” is available even if patient is not in AF prior to this admission ie if 2.1.3 “Atrial Fibrillation” = No then 2.1.7 answer options are not greyed out. – 2.1.7a - New question and validation – 2.1.7b - New question and validation – 2.1.8 - New question and validation

		<ul style="list-style-type: none"> – 2.8 - New question and validation – 2.9 - New question and validation – 2.9.1 - New question and validation – 2.9.2 - New question and validation – 2.9.3 - New question and validation – 2.9.4 - New question and validation – 2.9.5 - New question and validation – 2.9.6 - New question and validation – 2.9.7 - New question and validation – 2.9.8 - New question and validation – 2.9.9 - New question and validation – 2.9.10 - New question and validation – 2.9.11 - New question and validation – 2.9.12 - New question and validation – 2.9.13 - New question and validation – 2.9.14 - New question and validation – 2.9.15 - New question and validation – 2.12 - New question and validation – 2.13 - New question and validation – 2.14 - New question and validation – 2.14a - New question and validation – 2.15 - New question and validation – 2.15.1 - New question and validation – 3.3a - New question and validation – 3.3b - New question and validation – 3.3c - Change to previous question 3.3 – 8.4 – remove ‘Not Known’ option – 8.5 – remove ‘Not Known’ option – 8.6.1 – remove ‘Not Known’ option – 8.6.2 - remove ‘Not Known’ option – 8.6.3 - remove ‘Not Known’ option – 8.6.4 - remove ‘Not Known’ option – 8.7.1 - remove ‘Not Known’ option – 8.7.2 - remove ‘Not Known’ option – 8.7.3 - remove ‘Not Known’ option – 1.12.2 – validation change: ‘Not Known’ not available for patients with a postcode in England (1.7) – 2.11.7 <i>No longer required</i> <p>Updated to KCL logo</p>
NI 5.0.0	01 Jul 2021	<ul style="list-style-type: none"> – 2.1.1f – Addition sub question for 2.1: ‘Dementia’ – 2.4.1 – New question and validation: ‘Modality of first brain imaging after stroke:’ – 2.4.2 – New question: ‘Was artificial intelligence (AI) used to support the interpretation of the first brain imaging?’ – 2.11.0 – New question and validation: ‘Was patient referred for intra-arterial intervention for acute stroke?’ – 2.11.0a – New question: ‘Date and time of initial referral for intra-arterial intervention’ – 2.11.0b – New question: ‘Date and time ambulance transfer requested’ – 2.11.0c – New question: ‘Date and time ambulance departed referring hospital’ – 2.11.0d – New question and validation: ‘Was a helicopter used?’ – 2.11a – New sub question: ‘If no, reason a procedure (arterial puncture) not begun’ – 2.11.ci – New question: ‘Was the perfusion’ – 2.11.3 – Additional answer options: ‘General anaesthetic from the outset; General anaesthetic by conversion from lesser anaesthesia’ – 2.11.3a – New question and validation: ‘Specialty of anaesthetist (if present)’ – 2.11.4 – New answer option: ‘Training fellow/specialty trainee’ – 2.11.4a – New question: ‘What was the specialty of the second operator?’ – 2.11.4b – New question: ‘What intervention lab was used’ – 2.11.4c – New question and validation: ‘If monoplane, why?’ – 2.11.5 – Question modified from ‘Were any of the following used?’ to ‘Which method(s) were used to reopen the culprit occlusion?’ – 2.11.6bi – New sub question and validation: ‘Deployment of device not performed because’ – 2.11.6d – New question and validation: ‘Were any of the following procedures required?’ – 2.11.6e – New question and validation: ‘How many passes were required?’

	<ul style="list-style-type: none"> - 2.11.7 – New question with sub questions and validation: ‘ Were there any procedural complications?’ - 2.11.8 – New answer options: ‘2c’ - 2.11.9 – New answer options: ‘Stroke unit at receiving site; Stroke unit at referring site’ - 2.11.9a – New sub question and validation: ‘If transferred to ICU or HDU, what was the indication for high-level care?’ - 3.9 – New question: ‘It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?’ - 4.6.1 – New question and validation: ‘How many of the total therapy minutes were provided by a rehabilitation assistant?’ - 4.6.2 – New question and validation: ‘How many of the total therapy minutes were delivered by video/teletherapy?’ - 4.8 – New question: ‘Was the patient considered to require nursing care any point in this admission?’ - 4.8.1 – New question: ‘If yes, at what date was the patient no longer considered to require this care?’ - 4.8.2 – New question: ‘On how many days did the patient receive nursing care across their total stay in this hospital/team?’ - 4.8.3 – New question: ‘How many minutes of nursing care in total did the patient receive during their stay in this hospital/team?’ - 4.9 – New question: ‘Date patient screened for mood using a validated tool’ - 4.9.1 – New question: ‘If not screened, what was the reason?’ - 4.10 – New question: ‘Date patient screened for cognition using a simple standardised measure?’ - 4.10.1 – New question: ‘If not screened, what was the reason?’ - 7.13 – New question: ‘Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?’ - 7.13.1 – New question: ‘If Yes, was COVID-19’ - 7.14 – New question and validation: ‘It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?’ - 8.8 – New question: ‘Employment status prior to stroke’ - 8.8.1 – New question: ‘Employment status currently’ - 8.9 – New question: ‘EQ5D-5L score six months after stroke’
--	--