SSNAP Dataset for ESD /Community Rehab Teams

Version control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1</td>
<td>12 Dec 2012</td>
<td>- Questions relevant for ESD / Community Rehab Teams</td>
</tr>
<tr>
<td>2.1.1</td>
<td>4 Apr 2014</td>
<td>- Added in Sections 4 and 7 from Core Dataset</td>
</tr>
</tbody>
</table>

For queries, please contact ssnap@rcplondon.ac.uk

Webtool for data entry: www.strokeaudit.org
<table>
<thead>
<tr>
<th><strong>Hospital / Team</strong></th>
<th>Auto-completed on web tool</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Audit Number</strong></td>
<td>Auto-completed on web tool</td>
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</tbody>
</table>

**Demographics** (you may find it useful to keep a note of these patient details, but you will not need to enter them onto the webtool as they will have been entered already by the first team treating the patient)

1.1. **Hospital Number**

*(on webtool this is just for the first team treating the patient, but you may wish to record a permanent number for the patient specific to your organisation)*

1.2. **NHS Number** 10 character numeric or **No NHS Number**

1.3. **Surname**

1.4. **Forename**

1.5. **Date of birth**

1.6. **Gender** Male ○ Female ○

1.7. **Postcode of usual address** 8-4 alphanumerics 3 alphanumerics Free text (30 character limit)

**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**

4.4. **Was the patient considered to require this therapy at any point in this admission?**

<table>
<thead>
<tr>
<th>1. Physiotherapy</th>
<th>2. Occupational Therapy</th>
<th>3. Speech and language therapy</th>
<th>4. Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes○ No○</td>
<td>Yes○ No○</td>
<td>Yes○ No○</td>
<td>Yes○ No○</td>
</tr>
</tbody>
</table>

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?**

4.7. **Date rehabilitation goals agreed:**

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
</tr>
</thead>
<tbody>
<tr>
<td>dd</td>
<td>mm</td>
<td>yyyy</td>
<td>hh</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4.7.1. If no goals agreed, what was the reason?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not known ○ Patient medically unwell for entire admission ○</td>
</tr>
<tr>
<td>Patient refused ○ Patient has no impairments ○</td>
</tr>
<tr>
<td>Organisational reasons ○ Patient considered to have no rehabilitation potential ○</td>
</tr>
</tbody>
</table>
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? dd mm yyy

7.1.2 Did the patient die in a stroke unit? Yes ○ No ○

7.1.3 What hospital/team was the patient transferred to? Enter team code

7.2. Date/time of discharge from stroke unit dd mm yyy hh mm

7.3. Date/time of discharge/transfer from team dd mm yyy hh mm

7.3.1 Date patient considered by the multidisciplinary team to no longer require inpatient care? dd mm yyy

7.4. Modified Rankin Scale score at discharge/transfer 0 - 6 (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 ○
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? 0 - 100
7.9.3 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 ☐