Royal College of Physicians

Core Dataset Help Notes

Version	Date	Changes
1.1.1	12/12/2012	Core dataset helpnotes following pilot versions
1.1.2	23/04/2013	Official core dataset help notes
1.1.3	13/11/2013	Updated official core dataset help notes
1.1.4	20/02/2013	Updated official core dataset help notes
2.1.1	22/04/2014	Updated official core dataset help notes with additional new questions
2.1.2	02/07/2014	Updated official core dataset help notes
2.1.3	9/01/2015	Partial update
3.1.1	1/10/2015	Updated official core dataset help notes.
4.0.0	1/12/2017	Updated core dataset helpnotes following pilot versions

Version	Major amendments	Minor amendments	Clarifications/Additional information
1.1.2	None	Exclusion criteria 1.12.2, 8.1	1.11 , 1.11.3 , 1.14 , 2.3 , 2.6 , 4.1, 4.4 , 5.1 , 6.7.1 , 6.8.1, 7.7 , 7.10.1, 7.11 , 8.1 , 8.2.2
1.1.2	None		Comprehensive questions 7.101 and 7.102 added
1.1.3	None	4.4, 4.4.4, 6.7, 7.1, 8.2,	1.9, 1.11.1, 1.12.2, 1.14, 2.1.3, 2.1.6, 2.1.7, 2.3, 2.4, 2.5, 2.6.1 2.6.2.2, 2.8.1, 2.8.2, 2.10, 3.1, 3.1.1, 3.1.2 3.3 3.4, 3.5, 3.6, 3.7, 3.8, 4.5, 4.7.1, 6.1, 6.2, 6.3, 6.4, 6.5, 6.8, 6.9, 6.9.1, 6.9.2 7.1.3 7.4, 7.9.2, 7.10, 8.4.
1.1.4	None	8.1	
2.1.1	4.4.1, 6.11, 6.11.1, 6.11.2	1.14, 3.1, 3.1.2, 6.9.2, 7.3.1, 8.4, 8.5, 8.6, 8.7	
2.1.2	None	2.6.2.3	6.11
2.1.3	None	7.1	
3.1.1			Questions 2.11, 2.11.1, 2.11.2, 2.11.3, 2.11.4, 2.11.5, 2.11.6, 2.11.7, 2.11.8, 2.11.9 added
4.0.0			Questions 2.1.7, 2.1.7a, 2.1.7b, 2.1.8, 2.8, 2.9, 2.9.1, 2.9.2, 2.9.3, 2.9.4, 2.9.5, 2.9.6, 2.9.7, 2.9.8, 2.9.9, 2.9.10, 2.9.11, 2.9.12, 2.9.13, 2.9.14, 2.9.15, 2.12, 2.13, 2.14, 2.15, 2.15.1, 2.15.2, 3.3a, 3.3b, 3.3c

On behalf of the Intercollegiate Stroke Working Party
SSNAP helpdesk Mon-Fri 09:00-17:00 Tel: 020 3075 1318 E-mail: ssnap@rcplondon.ac.uk

Introduction

The Stroke Programme at the Royal College of Physicians (RCP) first conducted the National Sentinel Stroke Audit in 1998 and 1999, and demonstrated that although there were widespread variations in standards across the country, much was being done at local level to change services. Improvements were demonstrated in each of the subsequent rounds of the audit. The Stroke Improvement National Audit Programme (SINAP) began in 2010; this continued to demonstrate improvements in acute care and identified areas for improvement.

The SSNAP core dataset is based on standards agreed by the representatives of the Colleges and professional associations of the disciplines involved in the management of stroke (current membership of the ICSWP is listed at www.rcplondon.ac.uk/stroke).

The aims of the Sentinel Stroke National Audit Programme (SSNAP)

1. To audit against the National Clinical Guidelines for Stroke (4th edition, 2012), the NICE Quality Standard for stroke, the Accelerating Stroke Improvement metrics and the National Stroke Strategy
2. To enable trusts to benchmark the quality of their stroke services nationally and regionally
3. To measure the rate of changes in stroke service organisation and quality of care for stroke patients since the National Audit Office Report of 2010
4. To measure the extent to which the recommendations made in previous RCP Stroke Programme reports have been implemented
5. To measure progress in providing hyperacute services to a greater proportion of the stroke population
6. To measure provision of community specialist services for stroke.

SSNAP

- Builds on the work of the National Sentinel Stroke Audit and the Stroke Improvement National Audit Programme (SINAP)
- Prospectively collects a minimum dataset for every stroke patient
- Follows every patient's care through the entire stroke pathway from acute care to the community and 6 month follow-up assessment
- Collects outcome measures
- Provides regular, routine, reliable data to
  - benchmark services nationally and regionally
  - monitor progress against a background of change
  - support clinicians in identifying where improvements are needed, lobbying for change and celebrating success
  - empower patients to ask searching questions.

Planning SSNAP
This is a multidisciplinary audit. Involving all the disciplines at the planning stage of the audit will help with subsequent stages of the audit, particularly when it comes to taking action on the results. In order to have consistent and reliable results, anyone completing the audit should have access to this help booklet. We would encourage participants to enter data prospectively rather than retrospectively gathering the data from patient records.

Audit web tool
The audit data is collected via a web tool to provide good quality data, and to speed up the analysis and reporting. There are in-built data validation checks.

Data collection time frame
Data collection will be continuous until at least 31 March 2017.

Clinical involvement and supervision
Each hospital should designate a clinical lead for SSNAP who will have overall responsibility for data quality and will sign off that the processes for collecting and entering the data are robust. A deputy (second lead) should also be designated (who may or may not be a clinician). The second lead should be the user most responsible for the day to day submission of SSNAP data. This user will also serve as the first point of contact for SSNAP.

Inclusion Criteria for the audit
- All stroke patients admitted to hospital or who suffer acute stroke whilst in hospital
- Optional: TIA patients (inpatients and outpatients) and patients who elicit a response from the stroke team (stroke mimics)

Exclusion Criteria
- Subarachnoid haemorrhage (I60)
- Subdural and extradural haematoma (I62)
- Patient had the stroke episode more than 28 days before presenting at hospital
- Optional (i.e. you can exclude but do not have to exclude): A patient who had a stroke in another country and were initially admitted to a hospital abroad

Clock Start
We use the term ‘clock start’ in SSNAP. This refers to the date/time a patient arrives at the first hospital (i.e. as soon as they are in the hospital, not time of admission to a ward) except for those patients who were already in hospital at the time of new stroke occurrence, where ‘clock start’ refers to the date/time of onset of stroke symptoms.

Question no	Question	Answer options	Guidance / definitions
	Team	Auto-completed on web tool	This is used for identification and analysis of individual centre data.
	Patient audit number	Auto-completed on web tool	A record of the patient audit number should be kept by the hospital for future reference. Each patient audit number is only used once (even if the same patient is later re-admitted as a new care spell, they will have a new patient audit number). This number is useful to identify records within the audit whilst observing confidentiality of patient information.
1.1	Hospital number	Free text (30 character limit)	The permanent number for identifying the patient across all departments within your hospital.
1.2	NHS number	Either 10 character NHS Number OR "No NHS Number"	If the patient does not have an NHS number (if they are an overseas visitor, prisoner, traveller or in the armed forces) please select the option for No NHS Number. Otherwise, please make every effort to find this number. This is a unique national identifier for the patient. The NHS number is used for data linkage, e.g. to link the SSNAP record with Office for National Statistics to retrieve mortality data.
1.3	Surname	Free text (30 character limit)	If the patient's NHS number is not known, this must be the name used for GP registration. The patient's surname or other name used as a surname.
1.4	Forename	Free text (30 character limit)	If the patient's NHS number is not known, this must be the name used for GP registration. The patient's first personal name and, optionally, if separated by spaces, subsequent personal names.
1.5	Date of birth	dd/mm/yyyy	Please ensure: i) Correct year for date of birth and use the format dd/mm/yyyy ii) The patient is over 16 years of age. Age associated with severity of stroke is an important predictive factor for outcome, both in terms of mortality and resulting dependency.
1.6	Gender	Male; Female	To investigate any differences between men and women in prevalence or outcomes.
1.7	Postcode of usual address	First box: 2-4 alphanumerics Second box: 3 alphanumerics. The full postcode of the patient’s	Please enter the full postcode of the patient’s normal place of residence. The postcode is used for data linkage purposes, particularly where the NHS number is not known or potentially incorrect.

Question no	Question	Answer options	Guidance / definitions
		normal place of residence.	The postcode can also be used to investigate numbers and severity of stroke in different parts of the country and whether there are any geographical inequalities in service provision, quality of care or patient outcomes. For patients from overseas or has no fixed abode please enter the following into the postcode field: ZZ11 1ZZ.
1.8	Ethnicity	Either code A-Z OR "Not Known" These are the categories as specified by NHS and HSCIC: <u>White</u> A British B Irish C Any other White background <u>Mixed</u> D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background <u>Asian or Asian British</u> H Indian J Pakistani K Bangladeshi L Any other Asian	The ethnicity of a person, as specified by the person. Z= The person had been asked and had declined either because of refusal or genuine inability to choose. 99 'Not known' should be used where the patient had not been asked or the patient was not in a condition to be asked, e.g. unconscious. Ethnicity can be used to investigate numbers and severity of stroke for different ethnic groups and whether there are any inequalities in service provision, quality of care or patient outcomes.

Question no	Question	Answer options	Guidance / definitions
		background <u>Black or Black British</u> M Caribbean N African P Any other Black background <u>Other Ethnic Groups</u> R Chinese S Any other ethnic group Z Not stated 99 Not known Northern Ireland teams- please view page 11 of the import function user guide.	
1.9	What was the diagnosis?	Stroke; TIA; Other	If stroke is entered, please continue the core dataset. If TIA or Other is selected, please go straight to the TIA/Other section (non-mandatory). 'Move to TIA/Other patient dataset' tab will appear once either of these diagnoses is selected. All stroke patients should be entered onto the web tool, whether this is known prospectively (when they are admitted) or retrospectively (by checking hospital coding).

Question no	Question	Answer options	Guidance / definitions
			It is optional to enter TIA patients (inpatients and outpatients) and patients who elicit a response from the stroke team (stroke mimics). These records will not be included in our analysis but can be used for internal reporting purposes. See Stroke Dataset FAQ's Section 1 for more information.
1.10	Was the patient already an inpatient at the time of stroke?	Yes; No	Timings will be measured from time of onset of symptoms rather than time of arrival if patient was an inpatient. Previous national audits (Sentinel and SINAP) have shown the quality of care to be worse for patients who suffer a stroke while an inpatient.
1.11	Date/time of onset/awareness of symptoms	dd/mm/yyyy hh:mm	If best estimate or stroke during sleep (for 1.11.1), the date should be the date last known to be well. The time can be the time last known to be well, or left blank if a best estimate cannot be made (and not known entered for 1.11.2). However, for inpatients who had a stroke during sleep, enter the date/ time the patient first woke up (cannot be not known for inpatient, and should not be time last well, as for inpatient strokes, standards are measured from time of onset).
1.11.1	The date given is:	Precise; Best estimate; Stroke during sleep	For inpatients who had a stroke during sleep, enter the date/ time the patient first woke up.
1.11.2	The time given is:	Precise; Best estimate; Not known	*Cannot be "Precise" unless 1.11.1 = "Precise"* *Cannot be "Not Known" if 1.10="Yes"* For inpatients who had a stroke during sleep, enter the date/ time the patient first woke up.
1.12	Did the patient arrive by ambulance?	Yes; No	*If 1.10 = Yes then 1.12 will default to No*

Question no	Question	Answer options	Guidance / definitions
1.12.1	Ambulance trust	Select from drop down options on the web tool.	*Unavailable if 1.12 = No*
1.12.2	Computer Aided Despatch (CAD)/ Incident Number	Up to 11 characters or "Not known"	*Unavailable if 1.12 = No*. It is vital that efforts are made to find the CAD number, as this enables linkage of the record to ambulance data. Your A&E department should have access to the ambulance sheet (if paper) or the electronic ambulance record using the ambulance web viewer. The webtool will allow a CAD number of up to 11 characters.
1.13	Date/time patient arrived at first hospital	dd/mm/yyyy hh:mm	*Must be after 1.11 and 1.12 unless 1.10="Yes"* The soonest time should be used (preferably ambulance to hospital handover time). If, for instance, the time the patient is clerked as having arrived at hospital is later than the time on their scan, the scanning time should be used as arrival time, as the patient must have arrived at the hospital even though the time on the hospital system is later.
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	This looks at the number of acute stroke patients whose first ward of admission is a stroke unit AND who arrive on the stroke unit within 4 hours of clock start. See Section 1 of the Stroke Dataset FAQ's for more information. ~ CCG Outcomes Indicator Set for Domain 3: 'Improving recovery from stroke'
1.15	Date/time patient first arrived on stroke unit	Either Date/time OR "Did not stay on stroke unit"	*Cannot be "Did not stay on stroke unit" if 1.14 = "Stroke Unit"* The date and time must be after the date/time entered for patient arrival at hospital.
2.1	Did the patient have any of the following co-morbidities prior to this admission?		This refers to known diagnoses i.e. history in primary/secondary care health record or from regular prescribed medicines.

Question no	Question	Answer options	Guidance / definitions
2.1.1	Congestive Heart Failure	Yes; No	
2.1.2	Hypertension	Yes; No	
2.1.3	Atrial fibrillation	Yes; No	Answer 'Yes' if the patient is in persistent, permanent or paroxysmal atrial fibrillation.
2.1.4	Diabetes	Yes; No	
2.1.5	Stroke/TIA	Yes; No	
2.1.6	Was the patient on antiplatelet medication prior to admission?	Yes; No; No but	*Only answer if 2.1.3 is yes* 'No but' for the atrial fibrillation can only mean 'no - but for good reason' - which means the clinician judges that the individual patient risk of bleeding complication (related to anticoagulant or antiplatelet therapy) outweighs benefit in stroke risk reduction.
2.1.7	Was the patient on anticoagulant medication prior to admission?	Yes; No; No but	*Yes is available even if patient is not in AF prior to this admission.* To select 'No but' in answer to this question means that it is recorded that a prescriber judged the patient's risk of a bleeding complication to outweigh the benefit in stroke risk reduction. If this cannot be confirmed then the answer to this question is 'No'. Anticoagulation refers to treatment with an anticoagulant: Vitamin K antagonists: Warfarin and Phenindione DOAC = Direct Oral Anticoagulant: Apixaban (Eliquis), Rivaroxaban (Xarelto) and Dabigatran (Pradaxa), Edoxaban (Lixiana). Heparin = Includes treatment dose unfractionated heparin and Low Molecular Weight Heparin Anticoagulation does not refer to treatment with aspirin, clopidogrel or another antiplatelet agent.

Question no	Question	Answer options	Guidance / definitions
2.1.7(a)	What anticoagulation was the patient prescribed before their stroke?	• Vitamin K antagonist; (includes Warfarin) • DOAC; • Heparin	*Available if 2.1.7 = 'Yes'. Select all that apply.* Vitamin K antagonists: Warfarin and Phenindione DOAC = Direct Oral Anticoagulant: Apixaban (Eliquis), Rivaroxaban (Xarelto) and Dabigatran (Pradaxa), Edoxaban (Lixiana). Heparin = Includes treatment dose unfractionated heparin and Low Molecular Weight Heparin
2.1.7(b)	What was the patient's International Normalised ratio (INR) on arrival at hospital?	• Value range: 0.0 – 10.00 • INR not checked • Greater than 10	*Available if 2.1.7(a) = 'Vitamin K antagonist'* If inpatient, INR at the time of stroke onset should be used. International normalized ratio (INR) is a blood test to assess the anticoagulant effect of Warfarin and other Vitamin K antagonists. Many patients have their most recent INR recorded in their yellow anticoagulant book issued by the prescriber. If the INR is recorded is 'greater than 10' then select the 'Greater than 10' radio button.
2.1.8	Was a new diagnosis of AF made on admission?	• Yes • No	*Not available if AF is selected as comorbidity for 2.1.3.* The patient had not previously been diagnosed (known to have) or receiving treatment for Atrial Fibrillation, but on arrival at hospital the patient was found to be in AF.
2.2	What was the patient's modified Rankin scale score before this stroke?	0-5	0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance

Question no	Question	Answer options	Guidance / definitions
			3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention
2.3	What was the patient's NIHSS score on arrival?	Auto-calculation between (0 42) based on the numbers entered for each of the parts of the NIHSS. As this number is auto-calculated, it should not be filled in for either a direct entry or import.	National Institute for Health Stroke Scale (NIHSS) on arrival is collected on first contact with the stroke team. All clinicians should have received training in NIHSS, this is a web link to a free training site http://nihss-english.trainingcampus.net The NIHSS is one of the most sensitive measures of stroke severity and therefore is going to be used to assess case mix. This is going to be essential if we are going to be able to compare outcomes between units. In addition it is an essential component of stroke care that the neurological examination is done rigorously and in a standardised way. It is not only patients who are being thrombolysed who need such an evaluation. If the patient's neurological status is not measured then the patient is probably getting second rate care. See Section 2 of the Stroke Dataset FAQ's for more information
2.3.1	Level of Consciousness (LOC)	0; 1; 2; 3	There is no not known option for this part of the NIHSS so, at the very minimum, the level of consciousness on arrival must be entered. 0 = Alert; keenly responsive. 1 = Not alert; but arousable by minor stimulation to obey, answer, or respond. 2 = Not alert; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally

Question no	Question	Answer options	Guidance / definitions
			unresponsive, flaccid, and areflexic. Level of Consciousness: The investigator must choose a response if a full evaluation is prevented by such obstacles as an endotracheal tube, language barrier, orotracheal trauma/bandages. A 3 is scored only if the patient makes no movement (other than reflexive posturing) in response to noxious stimulation.
2.3.2	LOC Questions	0; 1; 2; Not known	0 = Answers both questions correctly. 1 = Answers one question correctly. 2 = Answers neither question correctly. The patient is asked the month and his/her age. The answer must be correct - there is no partial credit for being close. Aphasic and stuporous patients who do not comprehend the questions will score 2. Patients unable to speak because of endotracheal intubation, orotracheal trauma, and severe dysarthria from any cause, language barrier, or any other problem not secondary to aphasia are given a 1. It is important that only the initial answer be graded and that the examiner does not "help" the patient with verbal or non-verbal cues.
2.3.3	LOC Commands	0; 1; 2; Not known	0 = Performs both tasks correctly. 1 = Performs one task correctly. 2 = Performs neither task correctly. The patient is asked to open and close the eyes and then to grip and release the non-paretic hand. Substitute another one step command if the hands cannot be used. Credit is given if an unequivocal attempt is made but not completed due to weakness. If the patient does not respond to command, the task should be demonstrated to him or her (pantomime), and the result scored (i.e., follows none, one or two commands). Patients with trauma, amputation, or other physical impediments should be given suitable one-step commands. Only the first attempt is scored.
2.3.4	Best Gaze	0; 1; 2; Not known	0 = Normal. 1 = Partial gaze palsy; gaze is abnormal in one or both eyes, but forced

Question no	Question	Answer options	Guidance / definitions
			deviation or total gaze paresis is not present. 2 = Forced deviation, or total gaze paresis not overcome by the oculocephalic manoeuvre. Only horizontal eye movements will be tested. Voluntary or reflexive (oculocephalic) eye movements will be scored, but caloric testing is not done. If the patient has a conjugate deviation of the eyes that can be overcome by voluntary or reflexive activity, the score will be 1. If a patient has an isolated peripheral nerve paresis (CN III, IV or VI), score a 1. Gaze is testable in all aphasic patients. Patients with ocular trauma, bandages, pre-existing blindness, or other disorder of visual acuity or fields should be tested with reflexive movements, and a choice made by the investigator. Establishing eye contact and then moving about the patient from side to side will occasionally clarify the presence of partial gaze palsy.
2.3.5	Visual	0; 1; 2; 3; Not known	0 = No visual loss. 1 = Partial hemianopia. 2 = Complete hemianopia. 3 = Bilateral hemianopia (blind including cortical blindness). Visual fields (upper and lower quadrants) are tested by confrontation, using finger counting or visual threat, as appropriate. Patients may be encouraged, but if they look at the side of the moving fingers appropriately, this can be scored as normal. If there is unilateral blindness or enucleation, visual fields in the remaining eye are scored. Score 1 only if a clear-cut asymmetry, including quadrantanopia, is found. If patient is blind from any cause, score 3. Double simultaneous stimulation is performed at this point. If there is extinction, patient receives a 1, and the results are used to respond to item 11.
2.3.6	Facial Palsy	0; 1; 2; 3; Not known	0 = Normal symmetrical movements. 1 = Minor paralysis (flattened nasolabial fold, asymmetry on smiling). 2 = Partial paralysis (total or near-total paralysis of lower face). 3 = Complete paralysis of one or both sides (absence of facial movement in the upper and lower face).

Question no	Question	Answer options	Guidance / definitions
			Ask – or use pantomime to encourage – the patient to show teeth or raise eyebrows and close eyes. Score symmetry of grimace in response to noxious stimuli in the poorly responsive or non-comprehending patient. If facial trauma/bandages, orotracheal tube, tape or other physical barriers obscure the face, these should be removed to the extent possible.
2.3.7	Motor Arm (left)	0; 1; 2; 3; 4; Not known	0 = No drift; limb holds 90 (or 45) degrees for full 10 seconds. 1 = Drift; limb holds 90 (or 45) degrees, but drifts down before full 10 seconds; does not hit bed or other support. 2 = Some effort against gravity; limb cannot get to or maintain (if cued) 90 (or 45) degrees, drifts down to bed, but has some effort against gravity. 3 = No effort against gravity; limb falls. 4 = No movement. The limb is placed in the appropriate position: extend the arms (palms down) 90 degrees (if sitting) or 45 degrees (if supine). Drift is scored if the arm falls before 10 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-paretic arm. Only in the case of amputation or joint fusion at the shoulder, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.
2.3.8	Motor Arm (right)	0; 1; 2; 3; 4; Not known	As above for left arm
2.3.9	Motor Leg (left)	0; 1; 2; 3; 4; Not known	0 = No drift; leg holds 30-degree position for full 5 seconds. 1 = Drift; leg falls by the end of the 5-second period but does not hit bed. 2 = Some effort against gravity; leg falls to bed by 5 seconds, but has some effort against gravity. 3 = No effort against gravity; leg falls to bed immediately. 4 = No movement. The limb is placed in the appropriate position: hold the leg at 30 degrees (always tested supine). Drift is scored if the leg falls before 5 seconds. The aphasic patient is encouraged using urgency in the voice and pantomime, but not noxious stimulation. Each limb is tested in turn, beginning with the non-

Question no	Question	Answer options	Guidance / definitions
			paretic leg. Only in the case of amputation or joint fusion at the hip, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice.
2.3.10	Motor leg (right)	0; 1; 2; 3; 4; Not known	As above for left leg.
2.3.11	Limb Ataxia	0; 1; 2; Not known	0 = Absent. 1 = Present in one limb. 2 = Present in two limbs. This item is aimed at finding evidence of a unilateral cerebellar lesion. Test with eyes open. In case of visual defect, ensure testing is done in intact visual field. The finger-nose-finger and heel-shin tests are performed on both sides, and ataxia is scored only if present out of proportion to weakness. Ataxia is absent in the patient who cannot understand or is paralyzed. Only in the case of amputation or joint fusion, the examiner should record the score as untestable (UN), and clearly write the explanation for this choice. In case of blindness, test by having the patient touch nose from extended arm position.
2.3.12	Sensory	0; 1; 2; Not known	0 = Normal; no sensory loss. 1 = Mild-to-moderate sensory loss; patient feels pinprick is less sharp or is dull on the affected side; or there is a loss of superficial pain with pinprick, but patient is aware of being touched. 2 = Severe to total sensory loss; patient is not aware of being touched in the face, arm, and leg. Sensation or grimace to pinprick when tested, or withdrawal from noxious stimulus in the obtunded or aphasic patient. Only sensory loss attributed to stroke is scored as abnormal and the examiner should test as many body areas (arms [not hands], legs, trunk, face) as needed to accurately check for hemisensory loss. A score of 2, “severe or total sensory loss,” should only be given when a severe or total loss of sensation can be clearly demonstrated. Stuporous and aphasic patients will, therefore, probably score 1 or 0. The patient with brainstem stroke who has bilateral loss of sensation is scored 2. If the patient does not respond and is quadriplegic, score 2. Patients in a

Question no	Question	Answer options	Guidance / definitions
			coma (item 1a=3) are automatically given a 2 on this item.
2.3.13	Best Language	0; 1; 2; 3; Not known	0 = No aphasia; normal. 1 = Mild-to-moderate aphasia; some obvious loss of fluency or facility of comprehension, without significant limitation on ideas expressed or form of expression. Reduction of speech and/or comprehension, however, makes conversation about provided materials difficult or impossible. For example, in conversation about provided materials, examiner can identify picture or naming card content from patient's response. 2 = Severe aphasia; all communication is through fragmentary expression; great need for inference, questioning, and guessing by the listener. Range of information that can be exchanged is limited; listener carries burden of communication. Examiner cannot identify materials provided from patient response. 3 = Mute, global aphasia; no usable speech or auditory comprehension. A great deal of information about comprehension will be obtained during the preceding sections of the examination. For this scale item, the patient is asked to describe what is happening in a picture, to name the items on a naming sheet and to read from a list of sentences. Comprehension is judged from responses here, as well as to all of the commands in the preceding general neurological exam. If visual loss interferes with the tests, ask the patient to identify objects placed in the hand, repeat, and produce speech. The intubated patient should be asked to write. The patient in a coma (item 1a=3) will automatically score 3 on this item. The examiner must choose a score for the patient with stupor or limited cooperation, but a score of 3 should be used only if the patient is mute and follows no one-step commands.
2.3.14	Dysarthria	0; 1; 2; Not known	0 = Normal. 1 = Mild-to-moderate dysarthria; patient slurs at least some words and, at worst, can be understood with some difficulty. 2 = Severe dysarthria; patient's speech is so slurred as to be unintelligible in

Question no	Question	Answer options	Guidance / definitions
			the absence of or out of proportion to any dysphasia, or is mute/anarthric. If patient is thought to be normal, an adequate sample of speech must be obtained by asking patient to read or repeat words from a list. If the patient has severe aphasia, the clarity of articulation of spontaneous speech can be rated. Only if the patient is intubated or has other physical barriers to producing speech, the examiner should record the score as untestable (UN), and clearly write an explanation for this choice. Do not tell the patient why he or she is being tested.
2.3.15	Extinction and Inattention	0; 1; 2; Not known	0 = No abnormality. 1 = Visual, tactile, auditory, spatial, or personal inattention or extinction to bilateral simultaneous stimulation in one of the sensory modalities. 2 = Profound hemi-inattention or extinction to more than one modality; does not recognize own hand or orients to only one side of space. Extinction and Inattention (formerly Neglect): Sufficient information to identify neglect may be obtained during the prior testing. If the patient has a severe visual loss preventing visual double simultaneous stimulation, and the cutaneous stimuli are normal, the score is normal. If the patient has aphasia but does appear to attend to both sides, the score is normal. The presence of visual spatial neglect or anosagnosia may also be taken as evidence of abnormality. Since the abnormality is scored only if present, the item is never untestable.
2.4	Date and time of first brain imaging after stroke	Either Date dd/mm/yyyy and time hh:mm OR "Not imaged"	*Must be after 1.11 and 1.13* For anomalous cases (eg a patient has a brain scan at another hospital) please see Section 2 of the Stroke Dataset FAQ's for more guidance. ~ NICE Stroke Quality Standard: Statement 2
2.5	What was the type of stroke?	Either "Infarction" OR "Primary Intracerebral haemorrhage"	*Unavailable if 2.4="Not imaged"* Suspected haemorrhagic conversion of an infarct should be recorded as

Question no	Question	Answer options	Guidance / definitions
			'infarction'. A Venous stroke should be entered as a comment. See Section 2 of the Stroke Dataset FAQ's for more information on how to record exceptional cases.
2.6	Was the patient given thrombolysis?	Yes; No; No but	*"No but" auto-selected if 2.5 is "Primary Intracerebral Haemorrhage"* *Auto selected if 2.5="Primary Intracerebral haemorrhage"* ~ CCG Outcomes Indicator Set for Domain 3: 'Improving recovery from stroke' ~ NICE Quality Standard: Statement 3
2.6.1	If no, what was the reason?	Thrombolysis not available at hospital at all; Unable to scan quickly enough; Outside thrombolysis service hours; None	*Available if 2.6 = No* Only select one answer. Outside of thrombolysis service hours refers to the days and times when thrombolysis is provided by a team, not the window of time when a patient can be safely given thrombolysis.
2.6.2	If no but, please select the reasons:		Select all the reasons which apply 2.6.2.1 – 2.6.2.10.
2.6.2.1	Haemorrhagic stroke		*Auto selected if 2.5=PIH.*
2.6.2.2	Arrived outside thrombolysis time window		*Available if 2.6 = No but* This means outside of the window of time when patient can be safely given thrombolysis, not the days and times when thrombolysis is provided by a team, which if this is the reason is outside of service hours.
2.6.2.3	Stroke too mild or too severe		The RCP Guidelines were updated following the International Stroke Trial 3 (IST3). The NIHSS >25 was dropped as a reason for precluding thrombolysis and therefore stroke too severe cannot be the sole "no but" reason.
2.6.2.4	Contraindicated medication		

Question no	Question	Answer options	Guidance / definitions
2.6.2.5	Symptom onset time unknown/ wake-up stroke		
2.6.2.6	Symptoms improving		
2.6.2.7	Age		
2.6.2.8	Co-morbidity		This includes pre-stroke mRS ≥3
2.6.2.9	Patient or relative refusal		*Available if 2.6 = No but*
2.6.2.10	Other medical reason		*Available if 2.6 = No but*
2.7	Date and time patient was thrombolysed	Dd/mm/yyyy hh:mm	*Must be after 1.11 or 1.13 or 2.4 and cannot be more than 7 hours after 1.11 or 1.13* *Available if 2.6 = Yes*
2.8	Was there evidence of cerebral haemorrhage on brain imaging after the patient received thrombolysis/thrombectomy?	Yes; No	*Available if 2.6 or 2.11 = 'Yes'.* Record any report of intracranial haemorrhage (bleeding within the skull or brain) following treatment Note: Data from this question combined with Q2.9 will be used to measure the incidence of symptomatic intracranial haemorrhage after thrombolysis/thrombectomy.
2.8.1	If yes, which of the following complications?		*Available if 2.8 = Yes*
	Symptomatic intracranial haemorrhage		This can be abbreviated to SIH
	Angio oedema		This can be abbreviated to AO

Question no	Question	Answer options	Guidance / definitions
	Extracranial bleed		This can be abbreviated to EB
	Other		Before selecting 'Other' please confirm with a clinical stroke contact at your hospital that you have accurately selected the correct complication. Abbreviations such as SIH, AO and EB refer to complications highlighted above.
2.8.2	If other, please specify	Free text (30 character limit)	*Available if 2.8.4 "Other" is ticked* Before selecting 'Other' please confirm with a clinical stroke contact at your hospital that the complication was not one of the options above.
2.9	What was the patient's NIHSS score at 24 hours after thrombolysis / intra-arterial intervention?	Auto-calculation between (0 42) based on the numbers entered for each of the 15 components of the NIHSS. As this number is auto-calculated, it should not be filled in for either a direct entry or import.	*Available for all patients who have received thrombolysis or thrombectomy. Not known is no longer an option.* All clinicians should have received training in NIHSS, this is a web link to a free training site http://nihss-english.trainingcampus.net The NIHSS is one of the most sensitive measures of stroke severity and therefore is used to adjust for casemix and mortality. It is an essential component of stroke care that the neurological examination is done rigorously and in a standardised way. It is not only patients who are being thrombolysed who need such an evaluation. If the patient's neurological status is not measured then the patient is probably getting second rate care. See Section 2 of the Stroke Dataset FAQ's for more information Note: Data from this question combined with Q2.8 will be used to measure the incidence of symptomatic intracranial haemorrhage after thrombolysis/thrombectomy.

Question no	Question	Answer options	Guidance / definitions
2.10	Date and time of first swallow screen	Either date/time (dd/mm/yyyy hh:mm) OR "Patient not screened in first 4 hours"	*Must be after 1.11 and 1.13, and cannot be more than 4 hours after 1.13* If the patient's first swallow screen did not occur in the first 4 hours after clock start, a reason should be given in 2.10.1. There is another question which allows you to give the time of the patient's first swallow screen in section 3 of the dataset if it occurred between 4-72 hours of arrival. ~ NICE Stroke Quality Standard: Statement 4
2.10.1	If screening was not performed within 4 hours, what was the reason?	Enter the relevant code: NK = Not known OR = Organisational Reasons PR = Patient Refused PU = Patient medically unwell until time of screening	*Unavailable if date/time is entered for 2.10* Organisational reasons mean any issues with the service which meant that the screening was not performed within 4 hours e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed by clinical staff to be unable to be screened.
2.11	Did the patent receive an intra-arterial intervention for acute stroke?	Yes/No	Includes any intra-arterial intervention (for example, intra-arterial thrombolysis or clot retrieval).
2.11.1	Was the patient enrolled into a clinical trial of intra-arterial intervention?	Yes/No	Please answer *'Yes'* if the patient was randomised for an intra-arterial intervention as part of a randomised clinical trial.
2.11.2	What brain imaging technique was carried out prior to the intra-arterial intervention?		
a	CTA or MRA:	Yes/No	*CTA* (CT angiography) or *MRA* (MR angiography).

Question no	Question	Answer options	Guidance / definitions
b	Measurement of ASPECTS score:	Yes/No	*ASPECTS* (Alberta Stroke Program Early CT Score). Please answer *'Yes'* if this was measured and used in assessing the suitability of the patient intervention.
c	Assessment of ischaemic penumbra by perfusion imaging:	Yes/No	Please answer *'Yes'* if this was used in assessing the suitability of the patient intervention.
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 - Other	Please select the response that best reflects the anaesthesia used for the majority of the intervention.
2.11.4	What was the speciality of the lead operator?	- Interventional neuroradiologist - Interventional radiologist - Cardiologist - Other	If more than one operator was present then please select the speciality of the lead operator.
2.11.5	Were any of the following used?		

Question no	Question	Answer options	Guidance / definitions
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:		*DD/MM/YYYY* denotes Day/Month/Year *HH:MM* denotes Hours:Minutes Please record all times to the nearest minute.
a	Arterial puncture:	DD/MM/YYYY HH:MM	The time of the patient's first arterial puncture.
b	First deployment of device for thrombectomy or aspiration (if carried out):	DD/MM/YYYY HH:MM	Please leave blank if there was no deployment of device.
c	End of procedure (time of last angiographic run on treated vessel):	DD/MM/YYYY HH:MM	The time of the last angiographic image acquisition.
2.11.7	Did any of the following complications occur?		These are complications occurring prior to transferring the patient from the angiography suite or recovery area.

Question no	Question	Answer options	Guidance / definitions
a	Symptomatic intra-cranial haemorrhage:	Yes/No	Intracranial haemorrhage associated with deterioration in NIH Stroke Score or death.
b	Extra-cranial haemorrhage:	Yes/No	Extra-cranial haemorrhage from any site.
c	Other procedural complication resulting in harm to the patient:	Yes/No	
2.11.8	Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):		
a	Pre-intervention:	0 1 2a 2b 3	Modified TICI score.
b	Post-intervention:	0 1 2 2a 2b 3	Modified TICI score.
2.11.9	Where was the patient transferred after the completion of the procedure?	- Intensive care unit or high dependency unit - Stroke unit - Other	Where the patient was first transferred from the angiography suite or recovery area.

Question no	Question	Answer options	Guidance / definitions
2.12	What was the patient's systolic blood pressure on arrival at hospital?	Value range: 30-300 mmHG	*Answer required for all haemorrhagic patients (2.5=PIH)* Should be the first systolic blood pressure (SBP) taken in hospital. If stroke onset was in hospital, this should be the first SBP recorded after stroke onset. Blood pressure is measured in 'millimetres of mercury' (mmHg) and is written for example as 120/80mmHg (blood pressure is '120 over 80'). The first (or top) number is the **systolic** blood pressure (SBP).
2.13	Date/time of acute blood pressure lowering treatment, if given to the patient within 24 hours of onset?	dd/mm/yyyy hh:mm; Not given	*Answer required for all haemorrhagic patients (2.5=PIH).* Time of start of first dose or start of infusion/treatment If onset is known (1.11.1 is 'precise' and 1.11.2 is 'precise' or 'best estimate') date/time of blood pressure lowering must be within 24 hours of on 1.11 If onset is not known date/time of blood pressure lowering must be on the same day or next day of 1.11.
2.14	Date/time SBP (Systolic Blood Pressure) of 140mmHg or lower was first achieved?	dd/mm/yyyy hh:mm; Not given; Not achieved within 24 h	*Answer if Q2.12 is greater than 140* *Date/Time must be within 24 hours of clock start* Where a patient has an SBP of over 140 upon arrival at hospital (or onset of stroke if onset in hospital), and where the SBP is lowered to 140 or below, enter the first time an SBP of 140 or below was achieved, where this time is within 24 hours of clock start.
2.15	Was the patient given anticoagulant reversal therapy?	Yes; No	*Available if 2.1.7 = 'Yes' and 2.5 = PIH.* Refers to specific treatment to reverse the effects of anticoagulant treatment,

Question no	Question	Answer options	Guidance / definitions
			including PCC (Prothrombin Complex Concentrate), DOAC antidote, FFP (Fresh Frozen Plasma), Protamine and/or Vitamin K.
2.15.1	If yes, **2.15.1**. What reversal agent was given?	PCC; DOAC antidote; FFP; Protamine; Vitamin K	*Available if 2.15 = 'Yes'. Select all that apply.* PCC = Prothrombin Complex Concentrate DOAC antidote = Direct Oral Anticoagulant antidote. Includes Idarucizumab, Andexanet alfa. FFP = Fresh Frozen Plasma Protamine Vitamin K
2.15.2	Data and time reversal agent was given.	dd/mm/yyyy hh:mm	*Available if 2.15 = 'Yes'.* Time of START of infusion If more than one reversal agent given, enter time of first reversal agent. Must be after time of arrival/onset of stroke for inpatients.
3.1	Has it been decided in the first 72 hours that the patient is for palliative care?	Yes; No	For more information on this question please see Section 3 of the Stroke Dataset FAQ's.
3.1.1	Date of palliative care decision	dd/mm/yyyy	*Available if 3.1 = Yes Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* This can be answered if the palliative care decision was made in the first 72 hours after clock start. If not, you can answer this question in section 6 of the dataset.
3.1.2	If yes, does the patient have a plan fo r their end of life care?	Yes; No	*Available if 3.1 = Yes* Examples include the AMBER care bundle or Rapid Discharge Home to Die

Question no	Question	Answer options	Guidance / definitions
			Pathway.
3.2	Date/time first assessed by nurse trained in stroke management	Either date/time OR "No assessment in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.1* A nurse trained in 'stroke management' would have stroke specific management experience i.e. can check for deterioration of symptoms and take necessary steps. Perhaps (s)he is trained in transfers.
3.3	Date/time first assessed by stroke specialist consultant physician	Either date/time OR "No assessment in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* This can be an associate specialist. For information on the definition of a stroke specialist consultant physician please go to: http://www.basp.ac.uk/resources/resources.aspx
3.3a	Date and time contact was first made with a stroke specialist consultant physician about this case (whether in person or otherwise) following a clinical assessment	dd/mm/yyyy hh:mm No contact made	Enter the date and time of first contact with a stroke specialist consultant physician regarding this patient – this can be contact made in person, by telephone or via telemedicine. It can therefore be before the patient arrives in hospital if contact is made whilst in the ambulance for example. • This can be anyone who has been given responsibility by their Trust to provide consultant-level expertise to undertake the assessment and management of an acutely ill stroke patient. • This can be an associate specialist or a non-medical consultant, provided they meet the above requirements • A registrar would NOT meet these requirements • The use of non-medical consultants may therefore be acceptable.

Question no	Question	Answer options	Guidance / definitions
3.3b	How was first contact made with the stroke consultant?	In person; By telephone; Telemedicine	*Must be completed if Q3.3a is not "no contact made". Not available to answer if Q3.3a is "no contact made".*
3.3c	If first contact with consultant was not in person, date and time first assessed by stroke specialist consultant physician in person	dd/mm/yyyy hh:mm	*Only available if 3.3b= "by telephone" or "telemedicine"* *Must be after Q3.3a "Date and time contact was first made with a stroke specialist consultant physician about this case (whether in person or otherwise)".*
3.4	Date/time of first swallow screen	Either date/time OR "Patient not screened in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* *Unavailable if date/time entered for 2.10* This can be answered if the patient's first swallow screen was between 4-72 hours after clock start. If first swallow screen was within 4 hours please see question 2.10. We will not record the date/time of the first swallow screen if it took place >72 hours after clock start. See Section 3 of the Stroke Dataset FAQ's for more information on how to enter exceptional cases into the dataset.

Question no	Question	Answer options	Guidance / definitions
3.4.1	If screening was not performed within 72 hours, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused PU = Patient medically unwell in first 72 hours	Organisational reasons mean any issues with the service which meant that the screening was not performed within 72 hours e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed by clinical staff to be unable to be screened.
3.5	Date/time first assessed by an Occupational Therapist	Either date/time OR "No assessment in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* This can be answered if the patient was first assessed by an occupational therapist within 72 hours. If not, you can answer this question in section 6 of the dataset.
3.5.1	If assessment was not performed within 72 hours, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell ND = Patient had no relevant deficit	*Unavailable if date is entered for 3.5* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Patient had no appropriate functional deficit should be answered if the patient was not considered (by stroke doctor/stroke nurse) to have any problems requiring OT input. Organisational reasons mean any issues with the service which meant that the screening was not performed within 72 hours e.g. unavailability of staff.
3.6	Date/time first assessed by a Physiotherapist	Either date/time OR "No assessment in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* This can be answered if the patient was first assessed by a physiotherapist within 72 hours. If not, you can answer this question in section 6 of the dataset. ~ NICE Quality Standard: Statement 4
3.6.1	If assessment was not performed within 72 hours, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused PU = Patient medically	*Unavailable if date is entered for 3.6* Organisational reasons mean any issues with the service which meant that the screening was not performed within 72 hours e.g. unavailability of staff.

Question no	Question	Answer options	Guidance / definitions
		unwell ND = Patient had no relevant deficit	Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Patient had no appropriate functional deficit should be answered if the patient was not considered (by stroke doctor/stroke nurse) to have any problems requiring physiotherapy input.
3.7	Date/time communication first assessed by Speech and Language Therapist (SALT)	Either date/time OR "No assessment in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* This can be answered if the patient was first assessed by a speech and language therapist (SALT) within 72 hours of clock start. If not, you can answer this question in section 6 of the dataset. ~ NICE Quality Standard: Statement 5
3.7.1	If assessment was not performed within 72 hours, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused PU = Patient medically unwell ND = Patient had no relevant deficit	*Unavailable if date is entered for 3.7* Organisational reasons mean any issues with the service which meant that the screening was not performed within 72 hours e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Patient had no relevant deficit should be answered if the patient was not considered (by stroke doctor/stroke nurse) to have any communication problems requiring SALT input.

Question no	Question	Answer options	Guidance / definitions
3.8	Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment	Either date/time OR "No assessment in first 72 hours"	*Cannot be before 1.11 or 1.13 or more than 72 hours after 1.13* This can be answered if a patient received a formal swallow assessment by a speech and language therapist (SALT) within 72 hours of clock start. If not, you can answer this question in section 6 of the dataset. See Section 3 of the Stroke Dataset FAQ's for more information on how to enter exceptional cases into the dataset.
3.8.1	If assessment was not performed within 72 hours, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused PU = Patient medically unwell PS = Patient passed swallow screen	*Unavailable if date is entered for 3.8 Cannot enter "patient passed swallow screening" if 3.4= patient not screened in first 72 hours* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff for the period up until the assessment eventually took place. Organisational reasons mean any issues with the service which meant that the assessment was not performed within 72 hours e.g. unavailability of staff.
4.1	Date/time patient arrived at this hospital/team?	dd/mm/yyyy hh:mm	**All of section 4 must be answered by each team.** Auto-entry for first hospital based on 1.13 For inpatient teams, this is the date/time the patient arrived with your team. For non-inpatient teams (ESD and community rehab) this is the date/time the team first had face to face contact with the patient.
4.2	Which was the first ward the patient was admitted to in this hospital?	MAU/ AAU/ CDU; Stroke Unit; ITU/CCU/HDU; Other	Auto-entry for first hospital based on 1.14
4.3	Date/time patient arrived on stroke unit at this hospital?	Either date/time OR "Did not stay on stroke unit"	Auto-entry for first hospital based on 1.15 ~ NICE Quality Standard: Statement 6

Question no	Question	Answer options	Guidance / definitions
4.4	Was the patient considered to require this therapy at any point in this admission?	Yes; No (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	This collects whether a patient was considered by the team involved to require Occupational therapy, Physiotherapy, Speech and Language therapy and Psychology at any point during their total stay under the care of your team. SSNAP isn't measuring it for each day of the stay. If you wish to collect this data locally you can insert a comment at patient level within the webtool or use the custom fields function. Comments and custom fields are for local use and cannot be analysed centrally. If a patient is assessed and does not need any further therapy then the patient was not considered to require therapy at any point in this admission. Answer 'No'. If a patient is assessed and requires further therapy, answer 'Yes'. If Yes is selected, the assessment time should be included (in minutes) as part of the total therapy time. (Assessment + Therapy sessions time = Total amount of therapy received) NB: For Psychology this refers to delivery of care by psychologists or psychologist assistants. For more information please see Section 4 of the Stroke Dataset FAQ's.
4.4.1	At what date was the patient no longer considered to require this therapy ?	dd/mm/yyyy (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	This should be the date that the patient was no longer considered to have a deficit for each of the 4 therapies. Eg A date can be entered for when the patient no longer required speech and language therapy which can be before the date they no longer required other therapies.
4.5	On how many days did the patient receive this therapy across their total stay in this hospital/team?	Integer (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language	This is the total number of days on which the patient received each type of therapy from the day their care became the responsibility of this team to their discharge date from that team. It is collected separately for each hospital/team.

Question no	Question	Answer options	Guidance / definitions
		Therapy, Psychology)	*Cannot be more than the number of days they were in this hospital (i.e. 1.13 to 7.3 or 4.1 to 7.3)* *Available if 4.4.1 is Yes* The therapy may be provided by qualified or non-registered therapy assistants, including rehabilitation assistants, under supervision. For speech and language therapy it includes dysphagia and communication therapy. For psychologists it includes activities including assessment and treatment of mood, higher cognitive function and non-cognitive behavioural problems by psychologists or assistant psychologist. Therapy includes: - assessment and goal-directed therapy (i.e. towards goals that have been set and agreed by the team) - either individual or group therapy - home visits where the patient is present - Training patients and carers - Speech and Language Therapy refers to communication therapy and swallowing therapy In this definition therapy does not include • time for the therapist to travel to and from the patient • documentation • environmental visits • multidisciplinary team meetings • case conferences • case reviews For more information please see Section 4 of the Stroke Dataset FAQ's. ~ NICE Quality Standard: Statement 7

Question no	Question	Answer options	Guidance / definitions
4.6	How many minutes of this therapy in total did the patient receive during their stay in this hospital/team?	(For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	*Cannot be more than 300 minutes per day (300 x number of days)* Available if 4.5.1 > 0 - The stay refers to the team answering the question. The unit of measurement is minutes. The number of minutes must be a whole number - If two therapists of the same profession treat a patient at the same time, record the number of therapy minutes provided as the duration of the session e.g. 2 physiotherapists treating a patient for 45 minutes counts as 45 minutes of physiotherapy - If two therapists of different professions treat a patient at the same time, record the total number of minutes for each therapy e.g. a physiotherapist and occupational therapist treating a patient for 45 minutes counts as 45 minutes of physiotherapy and 45 minutes of occupational therapy - If one therapy assistant works on two different therapies during a 45 minutes session, record 45 minutes for only one profession or the times can be split (e.g. 25 minutes for one, 20 minutes for the other). - ~ NICE Quality Standard: Statement 7
4.7	Date rehabilitation goals agreed	Either date OR "No goals"	*Cannot be before 1.11 or 1.13/4.1* If rehabilitation goals were set without the direct involvement of the patient you can still enter the date they were agreed into 4.7, though is best practice to involve the patient and his/her family if possible. ~ NICE Quality Standard: Statement 5

Question no	Question	Answer options	Guidance / definitions
4.7.1	If no goals agreed, what was the reason?	PR - Patient refused OR - Organisational reasons MU - Patient medically unwell for entire admission NI - Patient has no impairments NRP - Patient considered to have no rehabilitation potential NK - Not known	*Available if 4.7 is Not known* Organisational reasons mean any issues with the service which meant that the screening was not performed within 4 hours e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Rehabilitation potential should be assessed by the MDT. In those assessed as having no rehabilitation potential it is expected the rationale is clearly documented in the case notes (e.g. advanced dementia).
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 0 = Alert; keenly responsive 1 = Not alert; but arousable by minor stimulation to obey, answer, or respond. 2 = Not alert; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic.	*Unavailable if 4.1 is more than 7 days after 1.13* Please note if a patient is transferred after 7 days, 5.1 – 5.3 must be complete before the record can be transferred. Based on patient's NIHSS Level of Consciousness (LOC) score: 0 = Alert; keenly responsive 1 = Not alert; but arousable by minor stimulation to obey, answer, or respond. 2 = Not alert; requires repeated stimulation to attend, or is obtunded and requires strong or painful stimulation to make movements (not stereotyped). 3 = Responds only with reflex motor or autonomic effects or totally unresponsive, flaccid, and areflexic. Please note that NIHSS does not need to be done again, LOC is a separate score and is an excellent prognostic indicator for outcome which historically was used in the Sentinel audit. This does not require a full assessment. First assessment should be noted and then in section 5 it should be recorded if the condition deteriorated from what was entered on admission.

Question no	Question	Answer options	Guidance / definitions
5.2	Did a 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	*Unavailable if 4.1 is more than 7 days after 1.13* This must be an infection which was not pre-existing but was contracted within 7 days of admission (or of stroke if patient was an inpatient at time of stroke).
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	*Unavailable if 4.1 is more than 7 days after 1.13* This must be pneumonia which was not pre-existing but was contracted within 7 days of admission for stroke (or of stroke if patient was an inpatient at time of stroke).
6.1	Date/time first assessed by an Occupational Therapist	Either date/time OR "No assessment by discharge"	*Cannot be before 1.11 or 1.13/4.1 and must be more than 72 hours after 1.13* *Unavailable if date/time is entered for 3.5 or if 3.5.1=ND* The date/time can only be entered if the first assessment by an Occupational therapist was >72 hours after clock start. If not, this question should be answered in section 3 of the dataset.
6.1.1	If no assessment, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission ND = Patient had no relevant deficit	*Available if 6.1= "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Patient had no relevant deficit should be answered if the patient was not considered (by stroke doctor/stroke nurse) to have any problems requiring occupational therapy input.

Question no	Question	Answer options	Guidance / definitions
6.2	Date/time first assessed by a Physiotherapist	Either date/time OR "No assessment by discharge"	*Cannot be before 1.11 or 1.13/4.1 and must be more than 72 hours after 1.13* *Unavailable if date/time is entered for 3.6 or if 3.6.1=ND* The date/time can only be entered if the first assessment by a Physiotherapist was >72 hours after clock start. If not, this question should be answered in section 3 of the dataset.
6.2.1	If no assessment, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission ND = Patient had no relevant deficit	*Available if 6.2= "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Patient had no relevant deficit should be answered if the patient was not considered (by stroke doctor/stroke nurse) to have any problems requiring physiotherapy input.
6.3	Date/time first assessed by Speech and Language Therapist?	Either date/time OR "No assessment by discharge"	*Cannot be before 1.11 or 1.13/4.1 and must be more than 72 hours after 1.13* *Unavailable if date/time is entered for 3.7 or if 3.7.1=ND.* The date/time can only be entered if the first assessment by a Speech and Language Therapist was >72 hours after clock start. If not, this question should be answered in section 3 of the dataset.
6.3.1	If no assessment, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission	*Available if 6.3= "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff.

Question no	Question	Answer options	Guidance / definitions
		ND = Patient had no relevant deficit	Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff. Patient had no relevant deficit should be answered if the patient was not considered (by stroke doctor/stroke nurse) to have any problems requiring speech and language therapy input.
6.4	Date/time assessed by a Speech and Language Therapist or another professional trained in dysphagia assessment?	Either date/time OR "No assessment by discharge"	*Cannot be before 1.11 or 1.13/4.1 and must be more than 72 hours after 1.13* *Unavailable if date/time is entered for 3.8 or if 3.8.1=PS* The date/time can only be entered if the assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment was >72 hours after clock start. If not, this question should be answered in section 3 of the dataset.
6.4.1	If no assessment, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission	*Available if 6.4= "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff.
6.5	Date urinary continence plan drawn up	Either date OR "No plan"	*Cannot be before 1.11 or 1.13/4.1* For more information on this question please see Section 6 of the FAQ's. ~ NICE Quality Standard: Statement 8
6.5.1	If no plan, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused PC = Patient continent	*Available if 6.5= "No plan"* Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff.

Question no	Question	Answer options	Guidance / definitions
6.6	Was the patient identified as being at high risk of malnutrition following nutritional screening?	Yes; No; Not screened	Screening should be undertaken using a validated nutrition screening tool e.g. Malnutrition Universal Screening Tool (MUST). A screening tool will usually assess weight and height, the presence of unintentional weight loss and poor intake. Surrogate measures for height e.g. ulna length, may be used in patients who are immobile or unsafe to stand. Screening should be carried out by nursing staff or other designated healthcare professionals with appropriate skills and training in the completion of the screening tool used in their unit. (Source: NICE guideline 32 Nutrition support for adults (2006)
6.6.1	If yes, date patient saw a dietitian	Either date OR "Not seen by a dietitian"	*Cannot be before 1.11 or 1.13/4.1* *Available if 6.6=Yes*
6.7	Date patient screened for mood using a validated tool	Either date OR "Not screened"	*Cannot be before 1.11 or 1.13/4.1* A validated tool for mood is one which has been approved for use within the trust/health board such as HADS, PHQ9 or for a person with aphasia, a more accessible one such as SAD-Q or DISCS. For more information on this question please see Section 6 of the Stroke Dataset FAQ's. ~ NICE Quality Standard: Statement 9
6.7.1	If not screened, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission	*Unavailable if date is entered for 6.7* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate mood screening by clinical staff. Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. There is no "Patient had no relevant deficit" answer option as this is a

Question no	Question	Answer options	Guidance / definitions
			screening, and the screening is required to determine if the patient had a deficit.
6.8	Date patient screened for cognition using a simple standardised measure?	Either date OR "Not screened"	*Cannot be before 1.11 or 1.13/4.1* Cognition measure is one which has been approved for use within the trust/ health board such as MOCA. For more information on this question please see Section 6 of the Stroke Dataset FAQ's. ~ NICE Quality Standard: Statement 9
6.8.1	If not screened, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission	*Unavailable if date is entered for 6.8* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate cognition screening by clinical staff. Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. There is no "Patient had no relevant deficit" answer option as this is a screening, and the screening is required to determine if the patient had a deficit.
6.9	Has it been decided by discharge that the patient is for palliative care?	Yes; No	*Unavailable if 3.1 = Yes* For more information on this question please see Section 6 of the Stroke Dataset FAQ's.

Question no	Question	Answer options	Guidance / definitions
6.9.1	Date of palliative care decision	dd/mm/yyyy	*Date must be more than 72 hours after 1.13* *Available if 6.9 = Yes* The date/time can only be entered if the palliative care decision was made >72 hours after clock start. If not, this question should be answered in section 3 of the dataset.
6.9.2	If yes, does the patient have a plan for their end of life care?	Yes; No	*Available if 6.9 = Yes* Examples include the AMBER care bundle or Rapid Discharge Home to Die Pathway.
6.10	Date rehabilitation goals agreed	Either date OR "No goals"	*Automatically calculated from the lowest value in 4.7, Leave blank for import* 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. ~ NICE Quality Standard: Statement 5
6.11	Was intermittent pneumatic compression applied?	Yes; No; Not Known	'Yes' should be answered when IPC sleeves of any kind were applied. 'No' should be answered if IPC sleeves were not applied regardless of the reason why they were not applied. 'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so. Most teams in England are involved in NHS Improving Quality's "IPC sleeves programme" and a requirement for this is to collect information on use of these sleeves for each patient.
6.11.1	If yes, what date was intermittent pneumatic compression first applied?	dd/mm/yyyy	*Cannot be before clock start and cannot be after 7.3*

Question no	Question	Answer options	Guidance / definitions
6.11.2	If yes, what date was intermittent pneumatic compression finally removed?	dd/mm/yyyy	*Cannot be before clock start or 6.11.1 and cannot be after 7.3*
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	The transfer in question 7.1 acts as a technical answer which facilitates the ability to transfer the patient record to the next team. 'Somewhere else' is a discharge from the care pathway to a place which is neither a care home nor the patient's home (e.g. this might be to a relative's home). This should also be used for teams not currently set up. This option can also be selected when a patient is transferred to another team which is not registered to take part in SSNAP. A comment should be entered to state the full name of the team the patient was transferred to. 'Inpatient care team' is any team (team as defined within SSNAP) which treats patients in an inpatient setting (e.g. an acute hospital, a community hospital, a bed based rehabilitation setting, an intermediate care setting) 'ESD/ community team' is for stroke/neurology specific or non-specialist Early Supported Discharge teams and community rehabilitation teams (i.e. treating patients outside of an inpatient setting). 'Was transferred to an inpatient/ESD/community team' should only be selected if the inpatient/ESD/community team the patient was transferred to is set up on the SSNAP webtool to receive SSNAP record transfers.If the team is not set up on SSNAP then 'Was transferred to an inpatient care team, not participating in SSNAP' or 'Was transferred to an ESD/community team, not

Question no	Question	Answer options	Guidance / definitions
			participating in SSNAP' should be selected. We encourage any teams which transfer patients to ESD/community teams that are not currently registered on SSNAP to contact those teams to encourage them to register to take part in the audit; if the inpatient/ESD/community team registers soon after, this can be changed so that the record can be transferred to them. The fact that the patient was discharged with ESD/community rehab team support will be noted in question 7.7 or 7.8. For more information on answering this question please see Section 7 of the Stroke Dataset FAQ's.
7.1.1	If patient died, what was the date of death?	dd/mm/yyyy	*Cannot be before 1.11 or 1.13/4.1* *Available if 7.1 is "Died in hospital"* There are no specific help notes for this sub-question.
7.1.2	Did the patient die in a stroke unit?	Yes; No	*Available if 7.1 is "Died in hospital".* *Unavailable if 4.3="Did not stay on stroke unit"* There are no specific help notes for this sub-question.
7.1.3	Which hospital/team was the patient transferred to?	Enter team code here	*Available if 7.1 = "Was transferred to another inpatient care team" or "Was transferred to an ESD / community team"* To find out the hospital/team code please go to Support > Resources > Team Codes Lists on the webtool. If the team the patient has been transferred to is not included in the lists, please contact the SSNAP helpdesk. For more information on answering this question please see Section 7 of the Stroke Dataset FAQ's.

Question no	Question	Answer options	Guidance / definitions
			Inactive teams This message appears: If a team is no longer accepting records on SSNAP (service reconfiguration etc). OR The team has been set up recently and is not currently participating (eg newly set up post acute team). Please have an agreement for local pathways as to when teams become active and transfers can begin. New teams should aim to start submitting records as soon as possible. If a team is unlikely to submit data soon, especially close to deadlines, it is appropriate to enter 'discharged somewhere else' in 7.1, then lock to discharge. If the record is already locked, please send through a request to the helpdesk, stating the reason for the unlock.
7.2	Date/time of discharge from stroke unit	dd/mm/yyyy / hh:mm	*Cannot be before 1.11 or 1.13/4.1 or 1.15/4.3* *Unavailable if 7.1.2="Yes".* *Unavailable if 4.3="Did not stay on stroke unit"*
7.3	Date/time of discharge/transfer from team	dd/mm/yyyy / hh:mm	*Cannot be before 1.11 or 1.13/4.1 or 1.15/4.3* *Unavailable if 7.1 = "Died in hospital" Cannot be before any dates/times in sections 1-6*
7.3.1	Date patient considered by the multidisciplinary team to no longer require inpatient care?	dd/mm/yyyy / hh:mm	*Cannot be before 1.11 or 1.13/4.1 or 1.15/4.3 and cannot be after 7.3* *Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team" OR "Was transferred to an ESD / community team"*
7.4	Modified Rankin Scale score at discharge/transfer	0-6	*0-5 if 7.1 is not died, 6 if 7.1 is died*

Question no	Question	Answer options	Guidance / definitions
			Defaults to 6 if 7.1 is died in hospital 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention 6: Dead For more information see Section 7 of the Stroke Dataset FAQ's.
7.5	If discharged to a care home, was the patient:	Either "Previously a resident" OR "Not previously a resident"	*Available if 7.1 = "Was discharged to a care home"*
7.5.1	If not previously a resident, is the new arrangement:	Either "Temporary" OR "Permanent"	*Available if 7.5 = "Not previously a resident"*
7.6	If discharged home, is the patient:	Living alone; Not living alone; Not known	*Available if 7.1 = "Was discharged home"*

Question no	Question	Answer options	Guidance / definitions
7.7	Was the patient discharged with an Early Supported Discharge multidisciplinary team?	Yes, stroke/neurology specific; Yes, non-specialist; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* Early supported discharge team refers to a multidisciplinary team which provides rehabilitation and support in a community setting with the aim of reducing the duration of hospital care for stroke patients. A stroke/neurology specific team is one which treats stroke/neurology patients solely. A non-specialist team treats other patients in addition to stroke and neurology patients. ~ NICE Quality Standard: Statement 10
7.8	Was the patient discharged with a multidisciplinary community rehabilitation team?	Yes, stroke/neurology specific; Yes, non-specialist; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* These would typically be part of a community neuro-rehabilitation team. Non-specialist team would typically be part of a generic intermediate rehabilitation team. ~ NICE Quality Standard: Statement 10
7.9	Did the patient require help with activities of daily living (ADL)?	Yes; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* Help means physical assistance rather than aids and adaptations.
7.9.1	What support did they receive?	Paid carers; Informal carers; Paid and informal carers; Paid care services unavailable; Patient refused	*Unavailable if 7.9 = No*

Question no	Question	Answer options	Guidance / definitions
7.9.2	At point of discharge, how many visits per week were social services going to provide?	Either numeric 0-100 OR "Not known"	*Available if 7.9 = Yes* Document number of visits per 7 day week. For more information see Section 7 of the Stroke Dataset FAQ's.
7.10	Is there documented evidence that the patient is in atrial fibrillation on discharge?	Yes; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* This question does not need to be answered for patients who died in hospital. Answer 'Yes' if the patient is in persistent, permanent or paroxysmal atrial fibrillation.
7.10.1	If yes, was the patient taking anticoagulation (non-antiplatelet agent) on discharge or discharged with a plan to start anticoagulation within the next month?	Yes; No; No but	*Available if 7.10 = Yes* Anti-coagulation refers to treatment with an anti-coagulant such as warfarin or phenindione, and not an antiplatelet such as aspirin or clopidogrel. A plan for anti-coagulation may consist of direction to the GP to review the patient for warfarin. This should be clear in the discharge letter or summary.
7.11	Is there documented evidence of joint care planning between health and social care for post discharge management?	Yes; No; Not applicable	Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team" Not applicable is for patients who are not resident in the UK, who refuse a health and/or social care assessment or intervention, or who only have a health *or* a social care need (not both) or no need for either. This is in the CCG Outcome Indicator Set in Domain 3: People who have had stroke are discharged from hospital with a joint health and social care plan. This identifies patients for whom there is documented evidence of joint care planning between health and social care for post discharge management. ~ CCG Outcomes Indicator Set for Domain 3; 'Improving recovery from stroke'

Question no	Question	Answer options	Guidance / definitions
7.12	Is there documentation of a named person for the patient and/or carer to contact after discharge?	Yes; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* The named person is dependent on the hospital policy. This can be anyone who has been involved in the patients care e.g. doctor, nurse, ward manager, key worker.
8.1	Did this patient have a follow-up assessment at 6 months post admission (plus or minus 2 months)?	Yes; No; No but; No, patient died within 6 months of admission	This is in the CCG Outcome Indicator Set for Domain 3 (Improving recovery from stroke) people who have had a stroke who receive a follow-up assessment between 4-8 months after initial admission. The National Stroke Strategy recognises that people, who have had a stroke, either living at home or in care homes, should be offered a review of their health and social care status and secondary prevention needs. Reviews should be a multifaceted assessment of need and should encompass: • Medicines/general health needs • Ongoing therapy and rehabilitation needs • Mood, memory cognitive and psychological status • Social care needs, carer wellbeing, finances and benefits, driving, travel and transport. Patients/carers should be given a copy of the outcome of the review and provided with contact details of who to contact for more information. No but should be answered: • For patients who decline the assessment or who do not attend an appointment offered

Question no	Question	Answer options	Guidance / definitions
			• Where an attempt is made to contact the patient, but they cannot be contacted as they are not registered with a GP or have moved overseas. • For patients who have another stroke after being discharged from inpatient care and are readmitted into hospital ~ CCG Outcomes Indicator Set for Domain 3; 'Improving recovery from stroke'
8.1.1	What was the date of follow-up?	dd/mm/yyyy	*Must be >4 months after 1.13* *Available if 8.1 = "Yes"*
8.1.2	How was the follow-up carried out:	In person; By telephone; Online; By post	*Available if 8.1 = "Yes"*
8.1.3	Which of the following professionals carried out the follow-up assessment:	GP; Stroke coordinator; Therapist; District/community nurse; Voluntary services employee; Secondary care clinician; Other	*Available if 8.1 = "Yes"* Six month review should be undertaken by an individual with stroke specialist competencies and training.
8.1.4	If other, please specify		Available if 8.1.3 = "Other"
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	*Unavailable unless 8.1 = "Yes"* 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. If the patient refuses consent, all patient identifiable information will be wiped from the webtool. Every effort should be made to seek consent however if this hasn't occurred we will still want the 6 month follow up information collected, this is why the dataset has the patient not asked option. Where there is are

Question no	Question	Answer options	Guidance / definitions
			comparatively high rate of patient not asked option chosen the RCP would seek assurance from the teams in question that there is an action plan in place to improve this.
8.2	Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?	Yes; No; No but	*Available if 8.1 = "Yes"* A validated tool for mood is one which has been approved for use within the trust/health board such as HADS, PHQ9 or for a person with aphasia a more accessible one such as SAD-Q or DISCS. 'No but' should be answered if a problem has already been detected and there is an action plan in place e.g. premorbid dementia or post-stroke cognitive impairment. For more information on this question please see Section 8 of the Stroke Dataset FAQ's.
8.2.1	Was the patient identified as needing support?	Yes; No	*Available if 8.2 = "Yes"*
8.2.2	Has the patient received psychological support for mood, behaviour or cognition since discharge?	Yes; No; No but	*Available if 8.2 = "Yes"* Mood, behaviour or cognitive disturbance could include anxiety, emotionalism, depression, adjustment, denial and difficulty coping emotionally and psychologically, which impedes recovery, problems with orientation and memory and inappropriate behaviour.
8.3	Where is the patient living?	Home; Care home; Other	*Available if 8.1 = "Yes"*
8.3.1	If other, please specify	Free text (30 character limit)	*Available if 8.3 = "Yes"*
8.4	What is the patient's modified Rankin Scale score?	0-6; Not Known	*Available for manual entry if 8.1 = "Yes"* 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all usual duties

Question no	Question	Answer options	Guidance / definitions
			and activities 2: Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3: Moderate disability; requiring some help, but able to walk without assistance 4: Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5: Severe disability; bedridden, incontinent and requiring constant nursing care and attention 6: Dead 'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so. ~ This collects Domain 3 of the NHS Outcomes Framework for 2013/14; 'Improving recovery from a stroke'
8.5	Is the patient in persistent, permanent or paroxysmal atrial fibrillation?	Yes; No; Not Known	*Available if 8.1 = "Yes"* 'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so. Paroxysmal atrial fibrillation means episodes that last longer than 30 seconds but less than 7 days (often less than 48 hours) and are self-terminating and recurrent. Persistent atrial fibrillation means episodes lasting longer than 7 days (spontaneous termination of the arrhythmia is unlikely to occur after this time). Permanent atrial fibrillation (AF) means AF that fails to terminate using cardioversion, or is terminated but relapses within 24 hours, or longstanding

Question no	Question	Answer options	Guidance / definitions
			AF (usually longer than 1 year) in which cardioversion has not been indicated or attempted (sometimes called accepted permanent AF).
8.6	Is the patient taking:		
8.6.1	Antiplatelet	Yes; No; Not Known	*Available if 8.1 = "Yes"* 'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.
8.6.2	Anticoagulant	Yes; No; Not Known	'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.
8.6.3	Lipid Lowering	Yes; No; Not Known	'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.
8.6.4	Antihypertensive	Yes; No; Not Known	'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.
8.7	Since their initial stroke, has the patient had any of the following:		
8.7.1	Stroke	Yes; No; Not Known	*Available if 8.1 = "Yes"* 'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.
8.7.2	Myocardial infarction	Yes; No; Not Known	'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.
8.7.3	Other illness requiring hospitalisation	Yes; No; Not Known	'Not known' should only be answered in exceptional circumstances where it is not possible to retrieve this information, despite efforts being made to do so.

Comprehensive Dataset Questions (not mandatory)

Casemix/ First 24 hours

Question no	Question	Answer options	Guidance / definitions
2.101	Has the patient had a TIA within the last month?	Yes; No; Not known	If yes to 2.1.5.
2.102	Was the patient assessed in a neurovascular clinic?	Yes; No	If yes to 2.11.
2.103	What was the patient's Barthel score before this stroke?	0-20	Barthel should be measured on 20 point scale. This score looks at independence and functional level pre-stroke and enables case-mix adjustment to be made.
2.104	What was the initial brain imaging modality?	CT; MRI	

Discharge/ Transfer (at end of section 7)

Question no	Question	Answer options	Guidance / definitions
7.101	Barthel score at discharge	0-20	Barthel should be measured on 20 point scale. This score looks at functional level at discharge. A measure of disability after stroke and the outcome of rehabilitation.
7.102	It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage.	Yes, patient gave consent; No, patient refused consent;	If the patient refuses consent, all patient identifiable information will be wiped from the webtool.

Question no	Question	Answer options	Guidance / definitions
	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?	Patient was not asked	