SSNAP | Sentinel Stroke National Audit Programme

KING'S College LONDON

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	09/01/2015	Partial update
3.1.1	01/10/2015	Updated official core dataset help notes.
4.0.0	01/12/2017	Updated core dataset helpnotes following pilot versions
5.0.0	01/07/2021	Updated core dataset helpnotes with additional new questions
5.1.1	15/09/2022	Updated official core dataset help notes

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
5.0.0	None	Introduction 1.8, 1.12, 1.12.2, 2.11, 2.11.4, 2.11.5, 2.11.8, 2.11.9, 4.6, 7.1, 8.4, 8.5, 8.6, 8.6.1, 8.6.2, 8.6.3, 8.6.4, 8.7, 8.7.1, 8.7.2, 8.7.3	Questions 2.1.6, 2.4.1, 2.4.2, 2.11.0, 2.11.0a, 2.11.0b, 2.11.0c, 2.11.0d, 2.11a, 2.11.2c, 2.11.3a, 2.11.4a, 2.11.4b, 2.11.4c, 2.11.6b(i), 2.11.6d, 2.11.6e, 2.11.7 (a-g), 2.11.9a, 3.9, 4.6.1, 4.6.2, 4.8, 4.8.1, 4.8.2, 4.8.3, 4.9, 4.9.1, 4.10, 4.10.1, 7.13, 7.13.1, 7.14, 8.8, 8.8.1, 8.9 (a-f) added Questions 2.104 and 7.102 removed
5.1.1	None	3.3, 3.3b	Questions: 1.9, 1.12.2, 1.14, 2.1.7(a), 2.3, 2.4, 2.6, 2.9, 2.10.1, 2.11.0, 2.11.0(b), 2.11.0(c), 2.11, 2.11.4, 3.1, 3.3, 3.3a, 3.3b, 3.4, 3.7, 4.6, 4.9, 4.10, 6.2, 6.3, 6.6, 6.7, 6.8, 7.1, 7.4, 7.7, 7.8, 7.9, 7.9.1, 7.9.2, 8.1, 8.2.2, 8.4,

On behalf of the Intercollegiate Stroke Working Party

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Introduction

The Sentinel Stroke National Audit Programme (SSNAP) is the national stroke audit based in the School of Population Health and Environmental Sciences at King's College London. It measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England, Wales and Northern Ireland. The National Stroke Audit was first conducted at the Royal College of Physicians (RCP) in 1998 and 1999 as part of the Stroke Programme. The audit 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 audit programme remained at the RCP until in 2017 it was decided that in order to maximise the impact and longevity of SSNAP, particularly in relation to research potential it would be hosted by King's College London. The latest contract commenced on 01 April 2018. Despite the change in audit provider SSNAP will maintain close links to RCP in the years ahead.

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 https://www.strokeaudit.org/getattachment/SSNAP-Governance/Intercollegiate-Stroke-Working-Party-membership.pdf.aspx?lang=en-GB).

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 2023.

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	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
		postcode of the patient's 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	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. Northern Ireland teams cannot enter patient identifiable information on the webtool. Ethnicity values are different for Northern Ireland. W White C Chinese IT Irish Traveller I Indian P Pakistani B Bangladeshi BC Black Caribbean BA Black African BO Black Other M Mixed Ethnic Group

Question no	Question	Answer options	Guidance / definitions
		L Any other Asian 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	O Other Ethnic Group R Roma Traveller
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). It is optional to enter TIA patients (inpatients and outpatients) and patients who elicit a response from the stroke team (stroke mimics). These records

Question no	Question	Answer options	Guidance / definitions
			will not be included in our analysis but can be used for internal reporting purposes. To change the diagnosis once a record is started: If the record was started as a stroke but confirmed as TIA or Other, select TIA or Other in question 1.9 to change diagnosis. If the record was started as Other or TIA, but confirmed as a stroke, choose either "TIA" or "Other" in the diagnosis drop-down on Clinical Case Management and find the record. Within the record choose "Change to stroke care" above the progress bar. The record will now show under "Acute stroke" in Clinical Case Management.
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.

<table>
<tr><th>Question no</th><th>Question</th><th>Answer options</th><th>Guidance / definitions</th></tr>
<tr><td>1.11.2</td><td>The time given is:</td><td>Precise; Best estimate; Not known</td><td>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.</td></tr>
<tr><td>1.12</td><td>Did the patient arrive by ambulance?</td><td>Yes; No</td><td>If 1.10 = Yes then 1.12 will default to No

If the ambulance is just transferring the patient from one hospital to another then you would select 'No' for Q1.12. This is because the ambulance team did not convey the patient to your hospital at the point of onset.</td></tr>
<tr><td>1.12.1</td><td>Ambulance trust</td><td>Select from drop down options on the web tool.</td><td>Unavailable if 1.12 = No</td></tr>
<tr><td>1.12.2</td><td>Computer Aided Despatch (CAD)/ Incident Number</td><td><u>Up to 11 characters</u></td><td>Unavailable if 1.12 = No.

CAD number must be added for patients with English postcodes

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 12 characters. Individual CAD format for each ambulance team is listed below:

<table>
<tr><th>Ambulance Trust:</th><th>Format:</th></tr>
<tr><td>South West Ambulance Service</td><td>8 digit numerical field unique to each incident</td></tr>
<tr><td rowspan="3">South East Coast Ambulance Service</td><td>e-PCR: any of the following 3 will be accepted as ‘CAD’:</td></tr>
<tr><td>1. Daily ID (four-digit)</td></tr>
<tr><td>2. Full CAD ID (eight-digit)</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Question no</th><th>Question</th><th>Answer options</th><th>Guidance / definitions</th></tr>
<tr><td></td><td></td><td></td><td>
<table>
<tr><td></td><td>3. Case reference (twelve-character).</td></tr>
<tr><td></td><td>Paper record: 4 digit</td></tr>
<tr><td>South Central Ambulance Service</td><td>11 digits reference starting with “S” and then the date & 4 digits</td></tr>
<tr><td>London Ambulance Service</td><td>4 digits</td></tr>
<tr><td>East Midlands Ambulance Service</td><td>8 digits</td></tr>
<tr><td rowspan="2">East of England Ambulance Service</td><td>e-PCR: 10 digits with – as a separator</td></tr>
<tr><td>Paper record: 10 digits formed of date & 4 digits</td></tr>
<tr><td>North East Ambulance Service</td><td>8 digits</td></tr>
<tr><td>North West Ambulance Service</td><td>8 digits</td></tr>
<tr><td>West Midlands Ambulance Service</td><td>8 digits</td></tr>
<tr><td>Yorkshire Ambulance Service</td><td>7 digits</td></tr>
<tr><td>Isle of Wight</td><td>11 digits reference starting “S” and then the date & 4 digits</td></tr>
</table>
</td></tr>
<tr><td>1.13</td><td>Date/time patient arrived at first hospital</td><td>dd/mm/yyyy hh:mm</td><td>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.</td></tr>
</table>

Question no	Question	Answer options	Guidance / definitions
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. For patients who are designated to be transferred for a thrombectomy, if you do not admit them to an inpatient ward while you await ambulance transfer and instead decide to keep the patient in accident and emergency, please select the ITU/CCU/HDU options.
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.
2.1.1a	Congestive Heart Failure	Yes; No	
2.1.1b	Hypertension	Yes; No	
2.1.1c	Atrial fibrillation	Yes; No	Answer 'Yes' if the patient is in persistent, permanent or paroxysmal atrial fibrillation.
2.1.1d	Diabetes	Yes; No	
2.1.1e	Stroke/TIA	Yes; No	
2.1.1f	Dementia	Yes; No	This must be a formal diagnosis of dementia made by a specialist
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.*

Question no	Question	Answer options	Guidance / definitions
			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.
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 Anticoagulation does not refer to treatment with aspirin, clopidogrel or another antiplatelet agent.
2.1.7(b)	What was the patient's International Normalised ratio (INR) on arrival at	• Value range: 0.0 – 10.00	*Available if 2.1.7(a) = 'Vitamin K antagonist'*

Question no	Question	Answer options	Guidance / definitions
	hospital (if inpatient, INR at the time of stroke onset)?	• INR not checked • Greater than 10	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 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	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. Further guidance is available here: https://www.mdcalc.com/nih-stroke-scale-score-nihss

Question no	Question	Answer options	Guidance / definitions
		not be filled in for either a direct entry or import.	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. If a patient is unconscious or comatose on arrival, "3" should be selected for LOC (2.3.1) and "not known" should be selected for all other instances where the NIHSS is untestable.
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 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.

Question no	Question	Answer options	Guidance / definitions
			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 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

Question no	Question	Answer options	Guidance / definitions
			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). 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.

Question no	Question	Answer options	Guidance / definitions
			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-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.

Question no	Question	Answer options	Guidance / definitions
			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 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

Question no	Question	Answer options	Guidance / definitions
			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 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

Question no	Question	Answer options	Guidance / definitions
			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* If the patient was scanned at another hospital: Option 1: If the first admitting hospital is registered on SSNAP then they should start a stroke record. Sections 1, 4, and the transfer information in section 7 should be answered. Question 2.4 'Date and time of first imaging after stroke' should also be answered by the first admitting hospital. The patient record can then be transferred to the next team treating the patient. Option 2: If the first admitting hospital is not registered on SSNAP, then the team to which the patient is transferred following the scan should start the record, entering the patient's scan time as one minute after the arrival time at the second team.

Question no	Question	Answer options	Guidance / definitions
			Option 3: If the stroke patient had their scan by a non-admitting team before being transferred to another hospital, then the admitting team should start the record and enter the time of scan as 1 minute after arrival at the admitting hospital. Option 4: For thrombectomy patients ONLY: the SSNAP record should be started by the team performing the initial assessments. If your team sees the patient first and performs the initial assessment (even if they were not admitted to the hospital) you should start the record and then transfer to the thrombectomy centre. If the patient was scanned as an outpatient but not admitted until a later date (e.g. 24 or 48 hours later): The date that the patient arrived as an outpatient should be entered as the arrival time on SSNAP. The scanning time can be entered as the time when the scan was carried out.
2.4.1	Modality of first brain imaging after stroke	Plain/non-contrast CT; CT Intracranial angiogram; CT Perfusion; Plain/non-contrast MRI; Contrast-enhanced MRA; MR Perfusion	*Unavailable if 2.4 = "Not imaged"* Only one option can be selected, and this should be the modality used for the first brain imaging after stroke onset. If multiple scans were carried out during the patient's first visit to the Radiology Department/scanner, the most advanced method of imaging should be selected, e.g. if the patient had a plain CT followed by a CT angiogram (CTA) followed by CT perfusion (CTP) on the same first visit to the scanner, then select 'CT perfusion'
2.4.2	Was artificial intelligence (AI) used to support the interpretation of the first brain imaging?	Yes; No	*Unavailable if 2.4 = "Not imaged"*

Question no	Question	Answer options	Guidance / definitions
			Artificial Intelligence (AI) is the use of a non-human software package to interpret brain imaging, even if the imaging is also subsequently interpreted by a radiologist. Examples of AI used in acute stroke imaging are Brainomix, RAPID, OLEA, MiSTAR, NICOLab, etc.
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 'infarction'. A Venous stroke should be entered as a comment.
2.6	Was the patient given thrombolysis?	Yes; No; No but	*"No but" auto-selected if 2.5 is "Primary Intracerebral Haemorrhage"*
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.

Question no	Question	Answer options	Guidance / definitions
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		
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		
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 12 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.

Question no	Question	Answer options	Guidance / definitions
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. Further guidance is available here: https://www.mdcalc.com/nih-stroke-scale-score-nihss 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. Note: Data from this question combined with Q2.8 will be used to measure the incidence of symptomatic intracranial haemorrhage after thrombolysis/thrombectomy. If the patient died within 24 hours of thrombolysis, please enter the last NIHSS score recorded after the patient received their thrombolysis.If a score was not recorded after thrombolysis, you will not be able to enter the NIHSS score and should enter "Not Known". If you can make a best estimate of the NIHSS score following thrombolysis, you can enter this instead.

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 1.13 if 1.10=No or after 1.11 if 1.10=Yes, and no more than 4 hours after.* 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.
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.
2.11.0	Was patient referred for intra-arterial intervention for acute stroke? (answered by first admitting team)	Yes, accepted at this team; Yes, accepted at another team; Yes, but declined; Not referred	*Available if 2.5 = "Infarction"* *To be answered by the first team* Includes any intra-arterial intervention (for example, intra-arterial thrombolysis or clot retrieval)

Question no	Question	Answer options	Guidance / definitions
			Please answer 'not referred' if the patient was not referred to another team for thrombectomy. Please answer 'yes, but declined' if the patient was referred for thrombectomy but the referral was not accepted by the thrombectomy performing team (so the patient was not transferred to the thrombectomy performing team). Please answer 'yes, accepted at another team' if the patient was referred to another team, the referral was accepted, and the patient was transferred to another team. If the patient was transferred to the thrombectomy performing team but the thrombectomy was not performed, please answer 'Yes, accepted at another team', complete the additional questions and transfer the record to the thrombectomy performing team. The thrombectomy performing team will then record that the thrombectomy was not performed and the reason why in their part of the record.
a	Date and time of initial referral for intra-arterial intervention	DD/MM/YYYY HH:MM	*Unavailable if 2.11.0 = "Not referred", "Yes, but declined" OR "Yes, accepted at this team"* *Must not be after date of death or discharge* *To be answered by referring team*

Question no	Question	Answer options	Guidance / definitions
			The referral time is the time the first conversation (electronic or actual) occurred between referring and receiving sites/teams in which the patient was discussed between referring and receiving sites/teams and put forward for intra-arterial treatment.
b	Date and time ambulance transfer requested	DD/MM/YYYY HH:MM	*Unavailable if 2.11.0 = "Not referred", "Yes, but declined" OR "Yes, accepted at this team"* *Must not be after date of death or discharge* *To be answered by transferring team* The ambulance transfer request time is the time the first conversation (electronic or actual) occurred in which a request was made for ambulance transfer to the receiving team. If a helicopter was used, this should be the date and time the helicopter transfer was requested by referring hospital.
c	Date and time ambulance departed referring hospital	DD/MM/YYYY HH:MM	*Unavailable if 2.11.0 = "Not referred", "Yes, but declined" OR "Yes, accepted at this team"* *Date and time of ambulance departure cannot be before date and time requested(2.11.0b).* *Must not be after date of death or discharge* *To be answered by transferring team* If a helicopter was used, this should be the date and time the helicopter transfer departed from referring hospital.

Question no	Question	Answer options	Guidance / definitions
d	Was a helicopter used?	Yes; No	*Unavailable if 2.11.0 = "Not referred", "Yes, but declined" OR "Yes, accepted at this team"* *To be answered by transferring team*
2.11	Did the patent receive an intra-arterial intervention for acute stroke?	Yes/No	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"* *To be answered by thrombectomy-performing team* Includes any intra-arterial intervention (for example, intra-arterial thrombolysis or clot retrieval). If the transfer to the thrombectomy team is within 24hrs Q2.11 can be left blank but if the transfer to the thrombectomy team is after 24hrs then 'no' can be answered for Q2.11 and indicate the most appropriate reason for Q2.11a e.g. 'other'.
a	If no, reason a procedure (arterial puncture) not begun:	Pre-procedure imaging demonstrated reperfusion – procedure not required; Pre-procedure imaging demonstrated the absence of salvageable brain tissue; Other reason	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"* This question refers to pre-procedure imaging performed at the **receiving site** only.
2.11.1	Was the patient enrolled into a clinical trial of intra-arterial intervention?	Yes/No	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"* Please answer *'Yes'* if the patient was randomised for an intra-arterial intervention as part of a randomised clinical trial.

Question no	Question	Answer options	Guidance / definitions
2.11.2	What brain imaging technique was carried out prior to the intra-arterial intervention?		*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"*
a	CTA or MRA:	Yes/No	*CTA* (CT angiography) or *MRA* (MR angiography).
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.
I	Was the perfusion	CT; MR; Both	
2.11.3	How was anaesthesia managed during the intra-arterial intervention?	- Local anaesthetic only (anaesthetist NOT present) - Local anaesthetic only (anaesthetist present) - Local anaesthetic and conscious sedation (anaesthetist NOT present) - Local anaesthetic and conscious sedation (anaesthetist present) - General anaesthetic from the outset	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"* Please select the response that best reflects the anaesthesia used for the majority of the intervention.

Question no	Question	Answer options	Guidance / definitions
		- General anaesthetic by conversion from lesser anaesthesia - Other	
a	Speciality of anaesthetist (if present)	Neuroanaesthetics; General anaesthetics; Not present	*Available if one of the following selected for 2.11.3: "Local anaesthetic only (anaesthetist present)"; "Local anaesthetic and conscious sedation (anaesthetist present)"; "General anaesthetic from the outset"; "General anaesthetic by conversion from lesser anaesthesia"; "Other"* *"Not Present" is NOT available if the following are selected for 2.12.3: "Local anaesthetic only (anaesthetist present)" OR "Local anaesthetic and conscious sedation (anaesthetist present)" selected for 2.12.3*
2.11.4	What was the speciality of the lead operator?	- Interventional neuroradiologist - Cardiologist - Interventional radiologist - Training fellow/speciality trainee - Other	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"*
a	What was the speciality of the second operator?	- Interventional neuroradiologist - Cardiologist - Interventional radiologist - Training fellow/ speciality trainee - Other - No second operator	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"*

Question no	Question	Answer options	Guidance / definitions
b	What intervention lab was used	- Biplane - Monoplane	*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"*
c	If monoplane, why?	- Biplane in use - Biplane being serviced - Other	*Unavailable if 2.11.4b = "Biplane"*
2.11.5	Which method(s) were used to reopen the culprit occlusion?		*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"*
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:		*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"* 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.

Question no	Question	Answer options	Guidance / definitions
b	First deployment of device for thrombectomy or aspiration (if carried out):	DD/MM/YYYY HH:MM OR Not performed	Please leave blank if there was no deployment of device.
	i. Deployment of device not performed because:	Unable to obtain arterial access; Procedure begun but unable to access the target intracranial vessel; Medical condition caused the procedure to be abandoned; Other reason	*Unavailable if date entered for 2.11.6b*
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.
d	Were any of the following procedures required?		
	Cervical Carotid stenting	Yes;No	
	Cervical Carotid angioplasty	Yes;No	
e	How many passes were required?	Value range: 1-10	

Question no	Question	Answer options	Guidance / definitions
2.11.7	Were there any procedural complications?		
	a. Distal clot migration/embolisation within the affected territory	Yes/No	
	b. Embolisation to a new territory	Yes/No	
	c. Intracerebral haemorrhage	Yes/No	
	d. Subarachnoid/intraventricular haemorrhage	Yes/No	
	e. Arterial dissection or perforation	Yes/ No	
	f. Vasospasm	Yes/No	
	g. Other	Yes/No	
2.11.8	Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):		*Unavailable if 2.11.0 = "Not referred" OR "Yes, but declined"*

<table>
<tr><th>Question no</th><th>Question</th><th>Answer options</th><th>Guidance / definitions</th></tr>
<tr><td>a</td><td>Pre-intervention:</td><td>0
1
2a
2b
2c
3</td><td>Select one value for the Modified TICI score with 2c

<table><tr><th>TICI grade</th><th>Original TICI</th><th>Modified TICI</th><th>Modified TICI with 2c</th></tr><tr><td>0/1</td><td>No/minimal reperfusion</td><td>No/minimal reperfusion</td><td>No/minimal reperfusion</td></tr><tr><td>2a</td><td>Partial filling <2/3 territory</td><td>Partial filling <50% territory</td><td>Partial filling <50% territory</td></tr><tr><td>2b</td><td>Partial filling ≥2/3 territory</td><td>Partial filling ≥50% territory</td><td>Partial filling ≥50% territory</td></tr><tr><td>2c</td><td>---</td><td>---</td><td>Near complete perfusion except slow flow or few distal cortical emboli</td></tr><tr><td>3</td><td>Complete perfusion</td><td>Complete perfusion</td><td>Complete perfusion</td></tr></table></td></tr>
<tr><td>b</td><td>Post-intervention:</td><td>0
1
2a
2b
2c
3</td><td>Select one value for the Modified TICI score with 2c</td></tr>
<tr><td>2.11.9</td><td>Where was the patient transferred after the completion of the procedure?</td><td>- Intensive care unit or high dependency unit
- Stroke unit at receiving site
- Stroke unit at referring site
- Other</td><td>Unavailable if 2.11.0 = “Not referred” OR “Yes, but declined”

Where the patient was first transferred from the angiography suite or recovery area.</td></tr>
</table>

Question no	Question	Answer options	Guidance / definitions
a	If transferred to ICU or HDU, what was the indication for high-level care?	- Unstable blood pressure - Airway or cardiac instability - Bleeding at procedure site - Failure to wake from anaesthetic - Agitation/need for sedation - Renal failure - Other - None of the above	*Unavailable if 2.11.9 = "Stroke unit at receiving site" OR "Stroke unit at referring site" OR "Other"*
2.12	What was the patient's systolic blood pressure on arrival at hospital (the first SBP taken in the hospital) (note: if onset in hospital, first systolic blood pressure after stroke onset) (mmHg)?	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? (if onset is unknown, only answer if given within 1 day of stroke 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

Question no	Question	Answer options	Guidance / definitions
			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 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, including PCC (Prothrombin Complex Concentrate), DOAC antidote, FFP (Fresh Frozen Plasma), Protamine and/or Vitamin K.
2.15.1	If yes, 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	Date and time reversal agent was given.	dd/mm/yyyy hh:mm	*Available if 2.15 = 'Yes'.* Time of START of infusion

Question no	Question	Answer options	Guidance / definitions
			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	If the patient was for palliative care in the first 72 hours but then recovers: If the decision for the patient to be put in palliative care was made in the first 72 hours and the patient did not recover within 72 hours, then palliative status (Q3.1=yes) cannot be changed. If the decision to put the patient on palliative care was made post 72 hours and the patient was subsequently taken off palliative care before discharge, then the palliative care question in section 6 can be amended to say 'no'. If you are actively treating the patient for their stroke then you should not tick the box for palliative care
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 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.

Question no	Question	Answer options	Guidance / definitions
3.3	Date/time first assessed by stroke specialist consultant	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* The assessment should be conducted by a trust-designated clinician with approved stroke competencies who is authorised to decide the patient's diagnosis and to initiate their management plan – including, but not limited to, reperfusion therapy This can be an associate specialist or a non-medical consultant, provided they meet the above requirements A registrar would NOT meet these requirements
3.3a	Date and time contact was first made with a stroke specialist consultant 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 regarding this patient following a clinical assessment. The purpose of the clinical assessment is to make a decision about how the patient will be managed, and therefore this assessment needs to be undertaken by a competent professional trained in undertaking assessments of neurological patients. The assessment would normally include examination of the patient, taking a detailed history, and would take the results of the imaging into consideration. First contact with the consultant can be made in person, by telephone or via telemedicine (must include the option to view the patient via video if required). In scenarios where the paramedic had received specific training to undertake assessments of neurological patients, this first contact could be before the patient arrives at hospital.

Question no	Question	Answer options	Guidance / definitions
3.3b	How was first contact made with the stroke consultant?	In person; By telephone; Telemedicine (must include the option to view the patient via video if required)	*Must be completed if Q3.3a is not "no contact made". Not available to answer if Q3.3a is "no contact made".* Telemedicine is a system of remote patient assessment including review of brain imaging. It may include direct visual assessment of the patient via video call, although this is not essential, but must always include clinician to clinician discussion and visual review of brain imaging to enable acute management of stroke patients by specialists not on site
3.3c	If first contact with consultant was not in person, date and time first assessed by stroke specialist consultant in person	dd/mm/yyyy hh:mm	*Only available if 3.3b= "by telephone" or "telemedicine"* (must include the option to view the patient via video if required)*"* *Must be after Q3.3a "Date and time contact was first made with a stroke specialist consultant 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. If a patient initially passed a swallow screen but then goes on to develop problems after 72hrs:

Question no	Question	Answer options	Guidance / definitions
			In this case the date and time of the initial swallow screen which the patient passed, should be entered into question 3.4. The fact that the patient subsequently developed problems can be reflected in section 4 of the (post-72h) dataset, which records the number of days/minutes the patient received each type of therapy.
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. This must include documented assessment/screening of typical impairment areas (this may not be first contact) which directly guides/contributes to formulation of a treatment plan. This could include joint assessment with another professional, or an acute ward round where the Therapist themselves has undertaken assessment- i.e., not an observer)
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.

Question no	Question	Answer options	Guidance / definitions
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. This must include documented assessment/screening of typical impairment areas (this may not be first contact) which directly guides/contributes to formulation of a treatment plan. This could include joint assessment with another professional, or an acute ward round where the Therapist themselves has undertaken assessment- i.e., not an observer)
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 unwell ND = Patient had no relevant deficit	*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. 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. This must include documented assessment/screening of typical impairment areas (this may not be first contact) which directly guides/contributes to formulation of a treatment plan. This could include joint assessment with

Question no	Question	Answer options	Guidance / definitions
			another professional, or an acute ward round where the Therapist themselves has undertaken assessment- i.e., not an observer)
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.
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.
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	*Unavailable if date is entered for 3.8 Cannot enter "patient passed swallow screening" if 3.4= patient not screened in first 72 hours*

Question no	Question	Answer options	Guidance / definitions
		PS = Patient passed swallow screen	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.
3.9	It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?	Yes, patient gave consent; No, patient refused consent; Patient not asked	SSNAP currently has approval under Section 251 to collect patient level data on the first six months of patient care, and so **it is not a requirement that the patient is asked for consent at this stage**. If the patient was not asked for consent, please record “patient not asked”. Patient identifiable information is not collected in Northern Ireland and so consent does not need to be sought. Northern Ireland teams should record “Not asked” for this question. If the patient refuses consent, all patient identifiable information will be wiped from the webtool. If patient medically unwell and cannot be asked, indicate 'patient not asked'
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

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 (even if they do not receive 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.
4.4.1	At what date was the patient no long er 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. E.g., 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. This is NOT when patients are unable to tolerate 45 minutes of therapy, but when a patient would no longer benefit from therapy. If the patient still has the necessary deficit at discharge (and still required therapy), even if they are medically unwell, please enter the discharge date as the date the patient no longer required therapy.

Question no	Question	Answer options	Guidance / definitions
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 Therapy, Psychology)	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. *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 • Setting up, supporting and advancing self-directed exercise programmes In this definition therapy does not include • time for the therapist to travel to and from the patient • documentation

Question no	Question	Answer options	Guidance / definitions
			• environmental visits • multidisciplinary team meetings • case conferences • case reviews
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 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. - 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). In this case "stay" refers to the time the patient spent with the team answering the question. You should enter the total amount of therapy the

Question no	Question	Answer options	Guidance / definitions
			patient received while in your care. The unit of measurement is minutes. The number of minutes must be a whole number.
4.6.1	How many of the total therapy minutes were provided by a rehabilitation assistant?	(For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	*Available if 4.5.1 > 0* This is the number of the total therapy minutes recorded in 4.6 that were provided specifically by a non-registered rehabilitation or therapy assistant. Where a session has required two members of staff (one qualified and one assistant), assume the session has been led by the qualified therapist, record all minutes as qualified and do not record any minutes as assistant provided. (i.e. Do not split minutes) 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). Please refer to patient notes to accurately determine the split per each therapy.
4.6.2	How many of the total therapy minutes were delivered by the video/teletherapy?	(For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	*Only available to non-inpatient teams* *Available if 4.5.1 > 0* This is the number of the total therapy minutes recorded in 4.6 that were provided specifically via video/teletherapy. This is contact with the patient that is therapeutic and focused on their rehabilitation goals. Please do not include activities relating to administration (e.g. booking appointments).
4.7	Date rehabilitation goals agreed	Either date OR "No goals"	*Cannot be before 1.11 or 1.13/4.1*

Question no	Question	Answer options	Guidance / definitions
			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.
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).
4.8	Was the patient considered to require nursing care at any point whilst under the care of this team?	Yes/No	*Only available to non-inpatient teams* This item should only record nursing from within your service. This relates to input provided by registered nurses and does not include care visits. This item collects whether a patient was considered by the team involved to require nursing care at any point during their total stay under the care of your team. SSNAP is not measuring nursing care for each day of the patient's 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. Note that comments and custom fields are for local use and cannot be analysed centrally.

Question no	Question	Answer options	Guidance / definitions
4.8.1	If yes, at what date was the patient no longer considered to require this care?	DD/MM/YYYY	*Only available to non-inpatient teams* *Must not be after date of death or discharge* This should be the date that the patient was no longer considered to have a requirement for nursing care from your team. This item should only record nursing from within your service.
4.8.2	On how many days did the patient receive nursing care across their total stay in this team?		*Only available to non-inpatient teams* *Cannot be more than the number of days they were in this hospital (i.e. 4.1 to 4.8.1)* *Available if 4.8 is Yes* This item should only record nursing from within your service. This is the total number of days on which the patient received nursing care from the day their care became the responsibility of this team to their discharge date from that team. It is collected separately for each team.

Question no	Question	Answer options	Guidance / definitions
4.8.3	How many minutes of nursing care in total did the patient receive whilst under the care of this team?		*Only available to non-inpatient teams* *Cannot be more than 1440 minutes per day (1440 x number of days)* *Available if 4.8.2 > 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 nurses treat a patient at the same time, record the number of minutes provided as the duration of the session e.g. 2 nurses treating a patient for 45 minutes counts as 45 minutes of nursing care This item should only record nursing from within your service.
4.9	Date patient screened for mood using a validated tool	DDMMYY; Not Screened	*Only available to non-inpatient teams* *Cannot be before 4.1* Patients should have a reassessment in the non-acute stage. A validated tool for mood is one which has been approved for use within the trust/health board such as HADS, BASDEC, PHQ9 or for a person with aphasia, a more accessible one such as SAD-Q, BOA or DISCS.

Question no	Question	Answer options	Guidance / definitions
4.9.1	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 4.9* Patient medically unwell should be answered if the patient was 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 screening, and the screening is required to determine if the patient had a deficit.
4.10	Date patient screened for cognition using a simple standardised measure?	DDMMYY; Not Screened	*Only available to non-inpatient teams* *Cannot be before 1.11 or 1.13/4.1* Patients should have a reassessment in the non-acute stage. Cognition measure is one which has been approved for use within the trust/ health board such as MOCA/OCS. A standardised measure is one with evidenced validity and efficacy for use in stroke. Locally developed screening tools are not applicable.

Question no	Question	Answer options	Guidance / definitions
4.10.1	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 4.10* Patient medically unwell should be answered if the patient was 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.
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. This must include documented assessment/screening of typical impairment areas (this may not be first contact) which directly guides/contributes to formulation of a treatment plan. This could include joint assessment with another professional, or an acute ward round where the Therapist themselves has undertaken assessment- i.e., not an observer)
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	*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.

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 occupational therapy input.
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. This must include documented assessment/screening of typical impairment areas (this may not be first contact) which directly guides/contributes to formulation of a treatment plan. This could include joint assessment with another professional, or an acute ward round where the Therapist themselves has undertaken assessment- i.e., not an observer)
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.

Question no	Question	Answer options	Guidance / definitions
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. This must include documented assessment/screening of typical impairment areas (this may not be first contact) which directly guides/contributes to formulation of a treatment plan. This could include joint assessment with another professional, or an acute ward round where the Therapist themselves has undertaken assessment- i.e., not an observer)
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 ND = Patient had no relevant deficit	*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. 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.

Question no	Question	Answer options	Guidance / definitions
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*
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.
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.

Question no	Question	Answer options	Guidance / definitions
			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. If a patient is screened and not identified as high risk of malnutrition, but is screened again due to their condition deteriorating and identified as high risk: The later screening result (high risk) should be entered as this way it can be recorded whether the patient was seen by a dietician when this was required.
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, BASDEC, PHQ9 or for a person with aphasia, a more accessible one such as SAD-Q, BOA or DISCS. All patients need to be screened to assess mood post-stroke, even if they have already been diagnosed with a mood disorder. The 5th edition of the National Clinical Guideline for Stroke recommendation 4.10.1.1A states: "People with stroke with one mood disorder (e.g. depression) should be assessed for others (e.g. anxiety)."
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.

Question no	Question	Answer options	Guidance / definitions
			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.
6.8	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/OCS. A standardised measure is one with evidenced validity and efficacy for use in stroke. Locally developed screening tools are not applicable. A cognition measure is one which has been approved for use within the trust/health board. Cognition and mood are interpretable; the NHS must provide suitable interpretation facilities where English is not spoken or is not the first language if appropriate. If the patient is medically unwell this can be indicated. If the barrier to assessing mood or cognition is aphasia there is a version of the mood assessment suitable for patients with aphasia and other communication difficulties following stroke called SADQ.
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.

Question no	Question	Answer options	Guidance / definitions
			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*
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.
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.

Question no	Question	Answer options	Guidance / definitions
			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*
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). 'Somewhere else' should be selected when the patient has left the stroke care pathway. '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.

Question no	Question	Answer options	Guidance / definitions
			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 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.
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"*
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"*
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. Inactive teams This message appears:

Question no	Question	Answer options	Guidance / definitions
			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"*

Question no	Question	Answer options	Guidance / definitions
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* 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 Should the mRS score be solely related to disability resulting from stroke or include general level of disability: The pre-morbid, discharge and six month modified Rankin Scale scores should be entered according to overall level of disability.
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. If a patient is discharged to a standalone ESD service, please answer (as appropriate), either: “Yes, stroke/neurology specific” or “Yes, non-specialist” to Q7.7, and “No” to 7.8. If a patient is discharged to a standalone CRT service, please answer (as appropriate), either: “Yes, stroke/neurology specific” or “Yes, non-specialist” to Q7.8, and “No” to 7.7. If a patient is discharged to a stroke/neuro-specific combined ESD-CRT service, please answer “Yes, stroke/neurology specific” to both 7.7 and 7.8.
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.

Question no	Question	Answer options	Guidance / definitions
			If a patient is discharged to a standalone ESD service, please answer (as appropriate), either: “Yes, stroke/neurology specific” or “Yes, non-specialist” to Q7.7, and “No” to 7.8. If a patient is discharged to a standalone CRT service, please answer (as appropriate), either: “Yes, stroke/neurology specific” or “Yes, non-specialist” to Q7.8, and “No” to 7.7. If a patient is discharged to a stroke/neuro-specific combined ESD-CRT service, please answer “Yes, stroke/neurology specific” to both 7.7 and 7.8.
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. If the patient has gone to a care home and is receiving 24/7 care, it depends on whether they would be having any extra visits from social services, if not then you would answer 0 for question 7.9.2. For questions 7.9 and 7.9.1 you can answer yes to support required for ADLs and state the kind of carer that will be providing that support to them at the care home.
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* If social services have allocated a personalised support budget to a patient can these visits be included:

Question no	Question	Answer options	Guidance / definitions
			Only funded visits should be included on SSNAP - this includes visits which are set up by patients or families that are being paid for through a personalised budget, but not just signposting visits - which are likely to be one-off.
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.
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.

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.
7.13	Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?	- Yes - No - Not Known/not tested	*Confirmed = a positive test (of any kind) OR a negative test but diagnosed with COVID clinically and treated as such.* *This question refers to the patient's particular stay at this team. As the question is referring to confirmed diagnosis*
7.13.1	If Yes, was COVID-19	- Present on admission (i.e. the admission COVID test was positive) - Confirmed subsequently during the patient's stay - Confirmed after death	*Unavailable if 7.13 is "No" OR "Not Known/not tested"*
7.14	It is not a requirement that the patient provides explicit consent for their patient identifiable details to be included in SSNAP at this stage. However, where efforts have been made to seek consent from the patient, please state if the patient gave consent for their identifiable information to be included in SSNAP?	- Yes, patient gave consent - No, patient refused consent - Patient not asked	Unavailable if 3.9 is "Yes, patient gave consent" OR "No, patient refused consent" For transferred patients, If Consent is set to "Yes, patient gave consent" OR "No, patient refused consent" in section 7 then that value will be copied to the new record and the section will have its status set to incomplete. SSNAP currently has approval under Section 251 to collect patient level data on the first six months of patient care, and **so it is not a requirement that the patient is asked for consent at this stage**. If the patient was not asked for consent, please record "patient not asked".

Question no	Question	Answer options	Guidance / definitions
			Patient identifiable information is not collected in Northern Ireland and so consent does not need to be sought. Northern Ireland teams should record "Not asked" for this question. If the patient refuses consent, all patient identifiable information will be wiped from the webtool If patient medically unwell and cannot be asked, indicate 'patient not asked'
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	National clinical guidelines recognise 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 It is vital that even if patients do not get a review because a service is not in place, that teams reflect this by selecting "No" in Q8.1 and locking the record to six months.
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"*

Question no	Question	Answer options	Guidance / definitions
			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 are comparatively high rates of patient not asked option chosen the KCL 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"* Discharge refers to discharge from acute team 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.
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,	Yes; No; No but	*Available if 8.2 = "Yes"*

Question no	Question	Answer options	Guidance / definitions
	behaviour or cognition since discharge?		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. Psychological support can be provided by any professional or voluntary sector service specifically trained in psychological support.
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	*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 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
8.5	Is the patient in persistent, permanent or paroxysmal atrial fibrillation?	Yes; No	*Available if 8.1 = "Yes"*

Question no	Question	Answer options	Guidance / definitions
			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 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	*Available if 8.1 = "Yes"*
8.6.2	Anticoagulant	Yes; No	
8.6.3	Lipid Lowering	Yes; No	
8.6.4	Antihypertensive	Yes; No	.
8.7	Since their initial stroke, has the patient had any of the following:		
8.7.1	Stroke	Yes; No	*Available if 8.1 = "Yes"*
8.7.2	Myocardial infarction	Yes; No	

Question no	Question	Answer options	Guidance / definitions
8.7.3	Other illness requiring hospitalisation	Yes; No	
8.8	Employment status prior to stroke	Working full-time; Working part-time; Retired; Studying or Training; Unemployed; Other	Prior to stroke = the time directly prior to stroke Full-time is the equivalent of 35 hours a week Full-time and part-time work includes paid, unpaid and voluntary work
8.8.1	Employment status currently	Working full-time; Working part-time; Retired; Studying or Training; Unemployed; Other	Full-time is the equivalent of 35 hours a week Full-time and part-time work includes paid, unpaid and voluntary work This question aims to identify if the stroke survivor is back at work and in meaningful employment to the extent that they were before their stroke. If the survivor is employed but not yet ready to return to work, please record this as 'Other'.
8.9	EQ5D-5L score six months after stroke		https://euroqol.org/publications/user-guides/ There should be only ONE response for each dimension Missing values are preferably coded as '9' Ambiguous values (e.g. two boxes are ticked for a single dimension) should be treated as missing values
a	Mobility	Value range: 1-5 OR 9	1: I have no problems in walking about 2: I have slight problems in walking about 3: I have moderate problems in walking about 4: I have severe problems in walking about 5: I am unable to walk about 9: Ambiguous or missing value
b	Self-Care	Value range: 1-5 OR 9	1: I have no problems washing or dressing myself 2: I have slight problems washing or dressing myself 3: I have moderate problems washing or dressing myself 4: I have severe problems washing or dressing myself

Question no	Question	Answer options	Guidance / definitions
			5: I am unable to wash or dress myself 9: Ambiguous or missing value
c	Usual activities (work, study, etc.)	Value range: 1-5 OR 9	1: I have no problems doing my usual activities 2: I have slight problems doing my usual activities 3: I have moderate problems doing my usual activities 4: I have severe problems doing my usual activities 5: I am unable to do my usual activities 9: Ambiguous or missing value
d	Pain/discomfort	Value range: 1-5 OR 9	1: I have no pain or discomfort 2: I have slight pain or discomfort 3: I have moderate pain or discomfort 4: I have severe pain or discomfort 5: I have extreme pain or discomfort 9: Ambiguous or missing value
e	Anxiety/Depression	Value range: 1-5 OR 9	1: I am not anxious or depressed 2: I am slightly anxious or depressed 3: I am moderately anxious or depressed 4: I am severely anxious or depressed 5: I am extremely anxious or depressed 9: Ambiguous or missing value
f	How is your health today?	Value range: 1-100 OR 999	100 means the best health you can imagine 0 means the worst health you can imagine Missing values should be coded as 999 If there is a discrepancy between where the respondent has placed the X and the number he/she has written in the box, administrators should use the number in the box

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.

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.