



### SSNAP Core Dataset 3.1.1

For queries, please contact [ssnap@rcplondon.ac.uk](mailto:ssnap@rcplondon.ac.uk)  
Webtool for data entry: [www.strokeaudit.org](http://www.strokeaudit.org)

NB. There is a stand-alone intra-arterial proforma available in the support section of the dataset which lists only those additional questions related to this intervention. The changes in the SSNAP Core Dataset 3.1.1 are all related to these new dataset questions.

Version	Date	Changes
1.1.1	12 Dec 2012	– Official core dataset following pilot versions (most recent 3.6.16)
1.1.2	18 Feb 2013	– 1.12.2 – word ‘incident’ added to question and allowed values changed to 10 characters – 2.8 – sub questions renumbered – 6.10 – word ‘First’ added
2.1.1	02 Apr 2014	– 1.14 Which was the first ward the patient was admitted to at the first hospital? (wording change from ‘Which was the first ward the patient was admitted to?’) – 3.1 Has it been decided in the first 72 hours that the patient is for palliative care? (wording change from ‘If yes, does the patient have a plan for their end of life care?’) – 3.1.2 – If yes, does the patient have a plan for their end of life care? (wording change from ‘Is the patient on an end of life pathway?’) – 4.4.1 – New question: ‘If yes, at what date was the patient no longer considered to require this therapy?’ – 4.5.1 Question removed – 4.6.1 Question removed – 6.9.2 – If yes, does the patient have a plan for their end of life care? (wording change from ‘Is the patient on an end of life pathway?’) – 6.11 - New question: ‘Was intermittent pneumatic compression applied?’ – 6.11.1 - New question: ‘If yes, what date was intermittent pneumatic compression first applied?’ <i>Validations: Cannot be before clock start and cannot be after 7.3</i> – 6.11.2 - New question: ‘If yes, what date was intermittent pneumatic compression finally removed?’ <i>Cannot be before clock start or 6.11.1 and cannot be after 7.3</i> – 7.1 – Additional answer options: ‘Was transferred to another inpatient care team, not participating in SSNAP’; ‘Was transferred to an ESD/community team, not participating in SSNAP’. <i>Validations: Selecting either of these has same effect as selecting ‘discharged somewhere else’</i> – 7.3.1 – ‘Date patient considered by the multidisciplinary team to no longer require inpatient care?’ (wording change from ‘Date patient considered by the multidisciplinary team to no longer require inpatient rehabilitation?’) – 8.4 – Additional answer option: ‘Not Known’. (‘What is the patient’s modified Rankin Scale score?’) – 8.5 – Additional answer option: ‘Not Known’. (‘Is the patient in persistent, permanent or paroxysmal atrial fibrillation?’) – 8.6.1 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Antiplatelet?’) – 8.6.2 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Anticoagulant?’) – 8.6.3 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Lipid Lowering?’) – 8.6.4 – Additional answer option: ‘Not Known’. (‘Is the patient taking: Antihypertensive?’) – 8.7.1 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Stroke’) – 8.7.2 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Myocardial infarction’) – 8.7.3 – Additional answer option: ‘Not Known’. (‘Since their initial stroke, has the patient had any of the following: Other illness requiring hospitalisation’)
3.1.1	01 Oct 2015	– 2.11 – New question – ‘Did the patient receive an intra-arterial intervention for acute stroke?’ – 2.11.1 – New question – ‘Was the patient enrolled into a clinical trial of intra-arterial

		<p>intervention?’</p> <ul style="list-style-type: none"> <li>– 2.11.2 – New question – ‘What brain imaging technique was carried out prior to the intra-arterial intervention?’</li> <li>– 2.11.3 – New question – ‘How was anaesthesia managed during the intra-arterial intervention?’</li> <li>– 2.11.4 – New question – ‘What was the speciality of the lead operator?’</li> <li>– 2.11.5 – New question – ‘Were any of the following used?’</li> <li>– 2.11.6 – New question – ‘Date and time of:’</li> <li>– 2.11.7 – New question – ‘Did any of the following complications occur?’</li> <li>– 2.11.8 – New question – ‘Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):’</li> <li>– 2.11.9 – New question – ‘Where was the patient transferred after the completion of the procedure?’</li> </ul>
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Hospital / Team   
Patient Audit Number

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

- 1.1. Hospital Number
- 1.2. NHS Number  or No NHS Number
- 1.3. Surname
- 1.4. Forename
- 1.5. Date of birth
- 1.6. Gender Male  Female
- 1.7. Postcode of usual address
- 1.8. Ethnicity  or Not Known
- 1.9. What was the diagnosis? Stroke  TIA  Other  (If TIA or Other please go to relevant section)
- 1.10. Was the patient already an inpatient at the time of stroke? Yes  No
- 1.11. Date/time of onset/awareness of symptoms
- 1.11.1. The date given is: Precise  Best estimate  Stroke during sleep
- 1.11.2. The time given is: Precise  Best estimate  Not known
- 1.12. Did the patient arrive by ambulance? Yes  No
- If yes:
- 1.12.1. Ambulance trust
- 1.12.2. Computer Aided Despatch (CAD) / Incident Number  or Not known
- 1.13. Date/ time patient arrived at first hospital
- 1.14. Which was the first ward the patient was admitted to at the first hospital?  
MAU/ AAU/ CDU  Stroke Unit  ITU/CCU/HDU  Other
- 1.15. Date/time patient first arrived on a stroke unit or Did not stay on stroke unit

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

- 2.1. Did the patient have any of the following co-morbidities prior to this admission?
- 2.1.1 Congestive Heart Failure: Yes  No
- 2.1.2 Hypertension: Yes  No
- 2.1.3 Atrial fibrillation: Yes  No
- 2.1.4 Diabetes: Yes  No
- 2.1.5 Stroke/TIA: Yes  No

- 2.1.6 If 2.1.3 is yes, was the patient on antiplatelet medication prior to admission? Yes  No  No but
- 2.1.7 If 2.1.3 is yes was the patient on anticoagulant medication prior to admission? Yes  No  No but

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

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

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

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

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

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

2.6.1 If no, what was the reason:

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

2.6.2 If no but, please select the reasons:

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

2.7. Date and time patient was thrombolysed

2.8. Did the patient have any complications from the thrombolysis? Yes  No

2.8.1 If yes, which of the following complications:

- Symptomatic intracranial haemorrhage  Angio oedema  Extracranial bleed  Other

2.8.2 If other, please specify

2.9. What was the patient's NIHSS score at 24 hours after thrombolysis?  or Not known

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

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

- 2.11 Did the patient receive an intra-arterial intervention for acute stroke? Yes  No
- 2.11.1 Was the patient enrolled into a clinical trial of intra-arterial intervention? Yes  No
- 2.11.2 What brain imaging technique(s) was carried out prior to the intra-arterial intervention?
- a. CTA or MRA Yes  No
- b. Measurement of ASPECTS score Yes  No
- c. Assessment of ischaemic penumbra by perfusion imaging Yes  No
- 2.11.3 How was anaesthesia managed during the intra-arterial intervention?
- Local anaesthetic only (anaesthetist NOT present)
- Local anaesthetic only (anaesthetist present)
- Local anaesthetic and conscious sedation (anaesthetist NOT present)
- Local anaesthetic and conscious sedation (anaesthetist present)
- General anaesthetic
- Other
- 2.11.4 What was the specialty of the lead operator?
- Interventional neuroradiologist
- Cardiologist
- Interventional radiologist
- Other
- 2.11.5 Were any of the following used?
- a. Thrombo-aspiration system Yes  No
- b. Stent retriever Yes  No
- c. Proximal balloon/flow arrest guide catheter Yes  No
- d. Distal access catheter Yes  No
- 2.11.6 Date and time of:
- a. Arterial puncture:
- b. First deployment of device for thrombectomy or aspiration       
 Not performed
- c. End of procedure (time of last angiographic run on treated vessel):
- 2.11.7 Did any of the following complications occur?
- a. Symptomatic intra-cranial haemorrhage Yes  No
- b. Extra-cranial haemorrhage Yes  No
- c. Other procedural complication resulting in harm to the patient Yes  No
- 2.11.8 Angiographic appearance of culprit vessel and result assessed by operator (modified TIC1 score)
- a. Pre intervention 0  1  2a  2b  3
- b. Post intervention 0  1  2a  2b  3
- 2.11.9 Where was the patient transferred after the completion of the procedure?
- Intensive care unit or high dependency unit
- Stroke unit
- Other

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

- 3.1. Has it been decided in the first 72 hours that the patient is for palliative care? Yes  No   
If yes:
- 3.1.1. Date of palliative care decision
- 3.1.2. If yes, does the patient have a plan for their end of life care? Yes  No
- 3.2. Date/time first assessed by nurse trained in stroke management       
or No assessment in first 72 hours
- 3.3. Date/time first assessed by stroke specialist consultant physician       
or No assessment in first 72 hours
- 3.4. Date/time of first swallow screen      (If date/time already entered for screening within 4 hours (2.10), 3.4 does not need to be answered)  
or Patient not screened in first 72 hours
- 3.4.1. If screening was not performed within 72 hours, what was the reason?
- 3.5. Date/time first assessed by an Occupational Therapist       
or No assessment in first 72 hours
- 3.5.1. If assessment was not performed within 72 hours, what was the reason?
- 3.6. Date/time first assessed by a Physiotherapist       
or No assessment in first 72 hours
- 3.6.1. If assessment was not performed within 72 hours, what was the reason?
- 3.7. Date/time communication first assessed by Speech and Language Therapist       
or No assessment in first 72 hours
- 3.7.1. If assessment was not performed within 72 hours, what was the reason?
- 3.8. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment       
or No assessment in first 72 hours
- 3.8.1. If assessment was not performed within 72 hours, what was the reason?

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

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

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

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

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

4.7. Date rehabilitation goals agreed:    or No goals

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

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

5.1. What was the patient's worst level of consciousness in the first 7 days following initial admission for stroke? (Based on patient's NIHSS Level of Consciousness (LOC) score): 0  1  2  3

5.2. Did the patient develop a urinary tract infection in the first 7 days following initial admission for stroke as defined by having a positive culture or clinically treated? Yes  No  Not known

5.3. Did the patient receive antibiotics for a newly acquired pneumonia in the first 7 days following initial admission for stroke? Yes  No  Not known

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

- 6.1. Date/time first assessed by an Occupational Therapist       
or No assessment by discharge
- 6.1.1 If no assessment, what was the reason?
- 6.2. Date/time first assessed by a Physiotherapist       
or No assessment by discharge
- 6.2.1 If no assessment, what was the reason?
- 6.3. Date/time communication first assessed by Speech and Language Therapist  
      
or No assessment by discharge
- 6.3.1 If no assessment, what was the reason?
- 6.4. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment  
      
or No assessment by discharge
- 6.4.1 If no assessment, what was the reason?
- 6.5. Date urinary continence plan drawn up    or No plan
- 6.5.1 If no plan, what was the reason?
- 6.6. Was the patient identified as being at high risk of malnutrition following nutritional screening?  
Yes  No  Not screened
- 6.6.1 If yes, date patient saw a dietitian    or Not seen by a dietitian
- 6.7. Date patient screened for mood using a validated tool    or Not screened
- 6.7.1 If not screened, what was the reason?
- 6.8. Date patient screened for cognition using a simple standardised measure?     
or Not screened
- 6.8.1 If not screened, what was the reason?
- 6.9. Has it been decided by discharge that the patient is for palliative care? Yes  No   
If yes:
- 6.9.1 Date of palliative care decision
- 6.9.2 If yes, does the patient have a plan for their end of life care? Yes  No
- 6.10. First date rehabilitation goals agreed:    or No goals
- This question is auto-completed. It will be based on the first date that is entered for 4.7. If no hospitals / care settings in the pathway enter a date (i.e. all select ‘no goals’), then ‘no goals’ will be selected here
- 6.11. Was intermittent pneumatic compression applied? Yes  No  Not Known
- 6.11.1 If yes, what date was intermittent pneumatic compression first applied?
- 6.11.2 If yes, what date was intermittent pneumatic compression finally removed?



## Discharge / Transfer

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

## Six month (post admission) follow-up assessment

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

8.1.1 What was the date of follow-up?

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

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

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

8.1.4 If other, please specify

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

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

8.2 Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?  
Yes  No  No but

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

8.2.2 If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?  
Yes  No  No but

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

8.3.1 If other, please specify

8.4. What is the patient's modified Rankin Scale score?  Not known

8.5. Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes  No  Not known

8.6. Is the patient taking:

8.6.1 Antiplatelet: Yes  No  Not known

8.6.2 Anticoagulant: Yes  No  Not known

8.6.3 Lipid Lowering: Yes  No  Not known

8.6.4 Antihypertensive: Yes  No  Not known

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

8.7.1 Stroke Yes  No  Not known

8.7.2 Myocardial infarction Yes  No  Not known

8.7.3 Other illness requiring hospitalisation Yes  No  Not known

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