Royal College of Physicians | Sentinel Stroke National Audit Programme (SSNAP)

SSNAP Core Dataset for Teams in Northern Ireland

Version control

Version	Date	Changes
NI 2.1.1	12 Dec 2012	– Official core dataset following pilot versions (most recent 3.6.16)
NI 2.1.1	4 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?') – 3.1.2 – 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?' – 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?' *Validations: Cannot be before clock start and cannot be after 7.3* – 6.11.2 – New question: 'If yes, what date was intermittent pneumatic compression finally removed?' *Cannot be before clock start or 6.11.1 and cannot be after 7.3* – 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'. *Validations: Selecting either of these has same effect as selecting 'discharged somewhere else'* – 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	- 2.11 – New question – 'Did the patent receive an intra-arterial intervention for acute stroke?' - 2.11.1 – New question – 'Was the patient enrolled into a clinical trial of intra-arterial intervention?' - 2.11.2 – New question – 'What brain imaging technique was carried out prior to the intra-arterial intervention?' - 2.11.3 – New question – 'How was anaesthesia managed during the intra-arterial intervention?' - 2.11.4 – New question – 'What was the speciality of the lead operator?' - 2.11.5 – New question – 'Were any of the following used?' - 2.11.6 – New question – 'Date and time of:' - 2.11.7 – New question – 'Did any of the following complications occur?' - 2.11.8 – New question – 'Angiographic appearance of culprit vessel and result assessed by operator (modified TCI score):' - 2.11.9 – New question – 'Where was the patient transferred after the completion of the procedure?'

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

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

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

Webtool for data entry: www.strokeaudit.org

Hospital / Team — Auto-completed on web tool

Patient Audit Number — Auto-completed on web tool

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

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

Free text (30 character limit)

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

10 character numeric or No NHS Number ○

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

Free text (30 character limit)

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

Free text (30 character limit)

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

Age on arrival 16-120 ***(teams in Northern Ireland must put age on arrival instead)***

1.6. Gender Male ○ Female ○

1.7. Postcode of usual address ***(teams in Northern Ireland can only put the first portion of the postcode on the webtool)*** 2-4 alphanumerics 3 alphanumerics

1.8. Ethnicity — Northern Ireland ethnicity list

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

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

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

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

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

1.12. Did the patient arrive by ambulance? Yes ○ No ○

If yes:

1.12.1. Ambulance trust — Default — Drop-down of all trusts

1.12.2. Computer Aided Despatch (CAD) Number 10 alphanumerics or Not known ○

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

1.14. Which was the first ward the patient was admitted to at the first hospital?

MAU/ AAU/ CDU ○ Stroke Unit ○ ITU/CCU/HDU ○ Other ○

1.15. Date/time patient first arrived on stroke unit dd mm yyyy hh mm 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 ○

If 2.1.3 (atrial fibrillation) is Yes:

2.1.6. Was the patient on antiplatelet medication prior to admission? Yes ○ No ○ No but ○
2.1.7. Was the patient on anticoagulant medication prior to admission? Yes ○ No ○ No but ○

2.2. What was the patient's modified Rankin Scale score before this stroke? [0 - 5]

2.3. What was the patient's NIHSS score on arrival? [Automated calculation of total score]

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

2.4. Date and time of first brain imaging after stroke [dd] [mm] [yyyy] [hh] [mm]
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 [dd] [mm] [yyyy] [hh] [mm]

2.8. Did the patient have any complications from the thrombolysis? Yes ○ No ○
If yes, which of the following complications:
2.8.1. Symptomatic intracranial haemorrhage ☐ 2.8.2. Angio oedema ☐ 2.8.3. Extracranial bleed ☐
2.8.4.Other ☐ 2.8.5. If other, please specify Free text (30 character limit)

2.9. What was the patient's NIHSS score at 24 hours after thrombolysis? 0 - 42 or Not known ○

2.10. Date and time of first swallow screen dd mm yyyy hh mm
or Patient not screened in first 4 hours ○
2.10.1. If screening was not performed within ***4 hours***, what was the reason? Enter relevant code (see appendix)

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: dd mm yyyy hh mm
b. First deployment of device for thrombectomy or aspiration dd mm yyyy hh mm
○ Not performed
c. End of procedure (time of last angiographic run on treated vessel): dd mm yyyy hh mm
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 TICI 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 depencency 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 dd mm yyyy
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 dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.3. Date/time first assessed by stroke specialist consultant physician dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.4. Date/time of first swallow screen dd mm yyyy hh mm (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? Enter relevant code

3.5. Date/time first assessed by an Occupational Therapist dd mm yyyy hh mm
or No assessment in first 72 hours ○
3.5.1. If assessment was not performed within 72 hours, what was the reason? Enter relevant code

3.6. Date/time first assessed by a Physiotherapist dd mm yyyy hh mm
or No assessment in first 72 hours ○
3.6.1. If assessment was not performed within 72 hours, what was the reason? Enter relevant code

3.7. Date/time communication first assessed by Speech and Language Therapist dd mm yyyy hh mm
or No assessment in first 72 hours ○
3.7.1. If assessment was not performed within 72 hours, what was the reason? Enter relevant code

3.8. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment dd mm yyyy hh mm
or No assessment in first 72 hours ○
3.8.1. If assessment was not performed within 72 hours, what was the reason? Enter relevant code

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

4.1. Date/ time patient arrived at this hospital/team dd mm yyyy hh mm

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

4.3. Date/time patient arrived on stroke unit at this hospital dd mm yyyy hh mm
or Did not stay on stroke unit ○

	.1 Physio therapy	.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○ No○	Yes○ No○	Yes○ No○	Yes○ No○
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: dd mm yyyy or No goals ○

4.7.1. If no goals agreed, what was the reason?	
Not known ○	Patient medically unwell for entire admission ○
Patient refused ○	Patient has no impairments ○
Organisational reasons ○	Patient considered to have no rehabilitation potential ○

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 dd mm yyyy hh mm
or No assessment by discharge ○
6.1.1. If no assessment, what was the reason? Enter relevant code

6.2. Date/time first assessed by a Physiotherapist dd mm yyyy hh mm
or No assessment by discharge ○
6.2.1. If no assessment, what was the reason? Enter relevant code

6.3. Date/time communication first assessed by Speech and Language Therapist dd mm yyyy hh mm
or No assessment by discharge ○
6.3.1. If no assessment, what was the reason? Enter relevant code

6.4. Date/time of formal swallow assessment by a Speech and Language Therapist or another professional trained in dysphagia assessment dd mm yyyy hh mm
or No assessment by discharge ○
6.4.1. If no assessment, what was the reason? Enter relevant code

6.5. Date urinary continence plan drawn up dd mm yyyy or No plan ○
6.5.1. If no plan, what was the reason? Enter relevant code

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 dd mm yyyy or Not seen by a dietitian ○

6.7. Date patient screened for mood using a validated tool dd mm yyyy or Not screened ○
6.7.1. If not screened, what was the reason? Enter relevant code

6.8. Date patient screened for cognition using a simple standardised measure? dd mm yyyy
or Not screened ○
6.8.1. If not screened, what was the reason? Enter relevant code

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 dd mm yyyy
6.9.2. If yes, does the patient have a plan for their end of life care? Yes ○ No ○

6.10. 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.
Date rehabilitation goals agreed: dd mm yyyy or No goals ○

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

6.11.1 If yes, what date was intermittent pneumatic compression first applied? dd mm yyyy
6.11.2 If yes, what date was intermittent pneumatic compression finally removed? dd mm yyyy

Discharge / Transfer

7.1. The patient:
Died ○
Was discharged to a care home ○
Was discharged home ○
Was discharged to somewhere else ○
Was transferred to another inpatient care team ○
Was transferred to an ESD / community team ○
Was transferred to another inpatient care team, not participating in SSNAP ○
Was transferred to an ESD/community team, not participating in SSNAP ○

7.1.1 If patient died, what was the date of death? dd mm yyyy

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

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

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

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

7.3.1. Date patient considered by the multidisciplinary team to no longer require inpatient care:
dd mm yyyy

7.4. Modified Rankin Scale score at discharge/transfer 0 - 6 (defaults to 6 if 7.1 is died in hospital)

7.5. If discharged to a care home, was the patient: Previously a resident ○ Not previously a resident ○
7.5.1. If not previously a resident, is the new arrangement: Temporary ○ Permanent ○

7.6. If discharged home, is the patient: Living alone ○ Not living alone ○ Not known ○

7.7. Was the patient discharged with an Early Supported Discharge multidisciplinary team?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○

7.8. Was the patient discharged with a multidisciplinary community rehabilitation team?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○

7.9. Did the patient require help with activities of daily living (ADL)? Yes ○ No ○
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? 0 - 100
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 ○

8.1.1. What was the date of follow-up? dd mm yyyy

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 Free text (30 character limit)

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 ○
If yes to 8.2:
8.2.1 Was the patient identified as needing support? Yes ○ No ○
If yes to 8.2.1:
8.2.2 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 Free text (30 character limit)

8.4. What is the patient's modified Rankin Scale score? 0 - 6 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.