SSNAP Core Inpatient Dataset 6.0.0 for Teams in Northern Ireland

Introduction to this dataset

The only difference in this 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. 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.

This dataset was previously called the SSNAP Core Dataset. From 1 October 2024, the datasets for inpatient and community teams separated to allow for each dataset to be more closely tailored to the differing requirements of the inpatient and community settings and so two datasets were created: the Core Inpatient Dataset (this document) and the Core Community Dataset. The SSNAP Core Dataset previously included section 8 (Six month follow-up assessment), however this is now available in a standalone document.

Inpatient teams are required to complete sections 1-7 of the dataset. **All SSNAP clinical teams must complete sections 4 and 7 of the dataset.** When a record has been transferred on the webtool to a new team, sections 4 and 7 will 'refresh' allowing the next team to re
cord and lock their data for these sections.

The SSNAP webtool has multiple validations (based on information supplied by teams in the preceding pathway and in preceding questions) and so some fields will either be pre-populated and/or unavailable to answer because they are not relevant.

Community teams are only required to answer sections 4 and 7 of the dataset. The questions in sections 4 and 7 of the Core Community Dataset are different to the questions in sections 4 and 7 of the Core Inpatient Dataset.

The provider performing the six month assessment completes section 8 of the dataset.

A log of changes made to the SSNAP Core Dataset can be found at the end of this document, available here.

More information and contacts

For queries, please contact ssnap@kcl.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)***

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

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

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

1.5. Date of birth ***(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 ○ Indeterminate ○

1.7. Postcode of usual address [2-4 alphanumeric]

(teams in Northern Ireland can only put the first portion of the postcode on the webtool)

1.8. Ethnicity [A – Z (select radio button)] or Not Known ○

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

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) / Incident Number [12 characters]

1.12.3. Was pre-hospital video triage used for this patient? Yes ○ No ○

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 a 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?

2.1.1a Congestive Heart Failure: Yes ○ No ○
2.1.1b Hypertension: Yes ○ No ○
2.1.1c Atrial fibrillation: Yes ○ No ○
2.1.1d Diabetes: Yes ○ No ○
2.1.1e Previous stroke/TIA: Yes ○ No ○
2.1.1f Dementia: Yes ○ No ○

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 ○

2.1.7(a) What anticoagulant was the patient prescribed before their stroke?

Vitamin K antagonists (includes Warfarin) ○
DOAC ○
Heparin ○

2.1.7(b) What was the patient's International Normalised ratio (INR) on arrival at hospital (if inpatient, INR at the time of stroke onset)?

Allowable values [0.0 – 10.0]
INR not checked ○
Greater than 10 ○

2.1.8. Was a new diagnosis of AF made on admission? Yes ○ No ○

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 ○

2.4a What brain imaging was performed on the patient's first visit to the imaging department? *(select all that apply)*

Plain/non-contrast CT ☐

CT Intracranial angiogram ☐
CT Perfusion ☐
Plain/non-contrast MRI ☐
Contrast-enhanced MRA ☐
MR Perfusion ☐

2.4b Date and time of all brain imaging within 24 hours of clock start

Plain/non-contrast CT [Date and time] or not performed ○
ASPECTS score [0-10] or Haemorrhagic stroke ○ (auto-selected if 2.5=PIH) or Not known ○
CT Intracranial angiogram [Date and time] or not performed ○
CT Perfusion [Date and time] or not performed ○
Plain/non-contrast MRI [Date and time] or not performed ○
Contrast-enhanced MRA [Date and time] or not performed ○
MR Perfusion [Date and time] or not performed ○

2.4.2. Was artificial intelligence (AI) used to support the interpretation of the first brain imaging?
Yes ○ No ○

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

2.5.1 Was the infarction a Large Vessel Occlusion? Yes ○ No ○

2.5.2 How was the Large Vessel Occlusion determined?
From an angiogram ○
Clinically without an angiogram ○

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

2.7.1. What thrombolysis agent was used? Alteplase ○ Tenecteplase ○

2.8. Was there evidence of cerebral haemorrhage on brain imaging after the patient received thrombolysis/thrombectomy? Yes ○ No ○

2.9. What was the patient's NIHSS score at 24 hours after thrombolysis / intra-arterial intervention?
Automated calculation of total score

		0	1	2	3	4	Not known
2.9.1	Level of Consciousness (LOC)	○	○	○	○		
2.9.2	LOC Questions	○	○	○			○
2.9.3	LOC Commands	○	○	○			○
2.9.4	Best Gaze	○	○	○			○
2.9.5	Visual	○	○	○	○		○
2.9.6	Facial Palsy	○	○	○	○		○
2.9.7	Motor Arm (left)	○	○	○	○	○	○
2.9.8	Motor Arm (right)	○	○	○	○	○	○
2.9.9	Motor Leg (left)	○	○	○	○	○	○
2.9.10	Motor Leg (right)	○	○	○	○	○	○
2.9.11	Limb Ataxia	○	○	○			○
2.9.12	Sensory	○	○	○			○
2.9.13	Best Language	○	○	○	○		○
2.9.14	Dysarthria	○	○	○			○
2.9.15	Extinction and Inattention	○	○	○			○

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?
Organisational reasons ○
Patient refused ○
Patient medically unwell until time of screening ○
Not known ○

2.11.0. Was patient referred for intra-arterial intervention for acute stroke?
Yes, accepted at this team ○
Yes, accepted at another team ○
Yes, but declined ○
Not referred ○

2.11.0a Date and time of initial referral for intra-arterial intervention dd mm yyyy hh mm

2.11.0b Date and time ambulance transfer requested dd mm yyyy hh mm

2.11.0c Date and time ambulance departed referring hospital dd mm yyyy hh mm

2.11.0d Was a helicopter used? Yes ○ No ○

2.11. Did the patient receive an intra-arterial intervention for acute stroke? Yes ○ No ○
2.11a 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 ○

2.11.1. Was the patient enrolled into a clinical trial of intra-arterial intervention? Yes ○ No ○

2.11.2. What further brain imaging was performed at the receiving site 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 ○
i. Was the perfusion scan: 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 ○
General anaesthetic by conversion from lesser anaesthesia ○
Other ○

2.11.3a Specialty of anaesthetist (if present):

Neuroanaesthetics ○
General anaesthetics ○
Not present ○

2.11.4 What was the specialty of the lead operator?

Interventional neuroradiologist ○
Cardiologist ○
Interventional radiologist ○
Training fellow/specialty trainee ○
Other ○

2.11.4a What was the specialty of the second operator?

Interventional neuroradiologist ○
Cardiologist ○
Interventional radiologist ○
Training fellow/specialty trainee ○
Other ○
No second operator ○

2.11.4b What intervention lab was used: Biplane ○ Monoplane ○

2.11.4c If monoplane, why? Biplane in use ○ Biplane being serviced ○ Other ○

2.11.5. Which method(s) were used to reopen the culprit occlusion?

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

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 ○

c. End of procedure (time of last angiographic run on treated vessel): dd mm yyyy hh mm

d. Were any of the following procedures required (*select all that apply*)?

Cervical Carotid stenting Yes ○ No ○
Cervical Carotid angioplasty Yes ○ No ○

e. How many passes were required? [1-10]

2.11.7. Were there any procedural complications? *(select all that apply)*

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 TICI score)

a. Pre intervention 0 ○ 1 ○ 2a ○ 2b ○ 2c ○ 3 ○

b. Post intervention 0 ○ 1 ○ 2a ○ 2b ○ 2c ○ 3 ○

2.11.9. Where was the patient transferred after the completion of the procedure?

Intensive care unit or high dependency unit	○
Stroke unit at receiving site	○
Stroke unit at referring site	○
Other	○

2.11.10. Where was the target occlusion?

Anterior/carotid territory	○
Posterior/vertebrobasilar territory	○

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)

[30-300] mmHg

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 or Not given ○

2.13.1. If blood pressure lowering treatment not given, what was the reason?

Blood pressure below treatment threshold	○
Stroke too severe	○
Symptom onset time unknown	○
BP lowering contraindicated	○
Patient palliated within 1 hour of admission	○
Patient or relative refusal	○
Other medical reason	○
No reason given	○

2.14. Date/time SBP (Systolic Blood Pressure) of 140mmHg or lower was first achieved?

dd mm yyyy hh mm or Not achieved within 24h ○

2.15. Was the patient given anticoagulant reversal therapy? Yes ○ No ○

2.15.1. What reversal agent was given?

PCC	☐
Idarucizumab	☐
Andexanet alfa	☐
FFP	☐
Protamine	☐
Vitamin K	☐

2.15.2. Date and time reversal agent was given | dd | mm | yyyy | hh | mm |

2.15.3. If anticoagulant reversal not given, what was the reason?

- Stroke too severe or too mild ○
- Symptom onset time unknown ○
- Patient palliated within 1 hour of admission ○
- Anticoagulant reversal contraindicated ○
- Patient or relative refusal ○
- Other medical reason ○
- No reason given ○

2.16. Did the patient have a neurosurgery consultation? Yes ○ No ○

2.16.1. Was the patient transferred for neurosurgery? Yes ○ No ○

2.17. What was the maximum diameter (in any direction) of the intracerebral haematoma on the first brain imaging? [0.1-20.0]cm

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 ○

3.2.0 Date/time first assessed (in person) by a stroke skilled clinician dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.2. Date/time first assessed by nurse trained in stroke management dd mm yyyy hh mm
or No assessment in first 72 hours ○

3.3a 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
or No assessment in first 72 hours ○

3.3b How was contact first made with the stroke consultant?
In person ○
By telephone ○
Telemedicine ○

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
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?
Organisational reasons ○
Patient refused ○
Patient medically unwell in first 72 hours ○
Not known ○

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?
Organisational reasons ○
Patient refused ○
Patient medically unwell ○
Patient had no relevant deficit ○
Not known ○

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?
Organisational reasons ○
Patient refused ○
Patient medically unwell ○
Patient had no relevant deficit ○

Not known ○

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?
Organisational reasons ○
Patient refused ○
Patient medically unwell ○
Patient had no relevant deficit ○
Not known ○

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?
Organisational reasons ○
Patient refused ○
Patient medically unwell ○
Patient passed swallow screening ○
Not known ○

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?
(not available to answer on webtool for teams in Northern Ireland)

<u>This admission (inpatient teams)</u> *(this section must be completed by every inpatient team)*

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 at 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. Motor function	2. Psychological function	3. Communication/swallowing	4. Other
4.4. Was the patient considered to require this care or treatment at any point in this admission?	Yes○ No○	Yes○ No○	Yes○ No○	Yes○ No○
4.5. On how many days did the patient receive this care/treatment across their total stay in this hospital/team?				
4.6. How many minutes of this care/treatment in total did the patient receive during their stay in this hospital/team?				
4.6a How many of these minutes were delivered by a rehabilitation assistant?				
4.6b How many of these minutes were delivered in a group session?				

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

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

Complications at 7 days *(if patient is transferred after 7 days, this section must be complete)*

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 ○ dd mm yyyy hh mm

6.1.1 If no assessment, what was the reason?
- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Patient had no relevant deficit ○
- Not known ○

6.2. Date/time first assessed by a Physiotherapist or No assessment by discharge ○ dd mm yyyy hh mm

6.2.1 If no assessment, what was the reason?
- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Patient had no relevant deficit ○
- Not known ○

6.3. Date/time communication first assessed by Speech and Language Therapist or No assessment by discharge ○ dd mm yyyy hh mm

6.3.1 If no assessment, what was the reason?
- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Patient had no relevant deficit ○
- Not known ○

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 ○ dd mm yyyy hh mm

6.4.1 If no assessment, what was the reason?
- Organisational reasons ○
- Patient refused ○
- Patient medically unwell for entire admission ○
- Not known ○

6.5. Date urinary continence plan drawn up dd mm yyyy or No plan ○

6.5.1 If no plan, what was the reason?
- Organisational reasons ○
- Patient refused ○
- Patient continent ○
- Not known ○

6.6. Was the patient identified as being at high risk of malnutrition following nutritional screening?
Yes ○ No ○ Not screened ○

6.6.1 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?
Organisational reasons ○
Patient refused ○
Patient medically unwell for entire admission ○
Not known ○

6.8. Date patient screened for cognition using a validated tool dd mm yyyy
or Not screened ○

6.8.1 If not screened, what was the reason?
Organisational reasons ○
Patient refused ○
Patient medically unwell for entire admission ○
Not known ○

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. First date rehabilitation goals agreed: dd mm yyyy 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 ○

6.12. Date/time first assessed by a Psychologist dd mm yyyy hh mm
or No assessment by discharge ○

6.12.1 If no assessment, what was the reason?
Organisational reasons ○
Patient refused ○
Patient medically unwell for entire admission ○
Patient had no relevant deficit ○
Not known ○

6.13. Date patient screened for visual impairment using a standardised tool dd mm yyyy
or Not screened ○

6.13.1 If not screened, what was the reason?
Organisational reasons ○
Patient refused ○
Patient medically unwell for entire admission ○
Not known ○

6.14. Date/time first assessed by an Orthoptist dd mm yyyy hh mm
or No assessment by discharge ○

6.14.1 If no assessment, what was the reason?

Organisational reasons	○
Patient refused	○
Patient medically unwell for entire admission	○
Patient had no relevant deficit	○
Scheduled outpatient appointment	○
Not known	○

6.15. What was the patient's employment status prior to stroke?

Working full-time	○
Working part-time	○
Retired	○
Studying or training	○
Unemployed	○
Other	○

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

7.1.4 If discharged to ESD/community team, where is the patient living?
Home ○ Care home ○ Other ○

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 ○

7.8.1 Was the patient discharged with a combined ESD-CRT service?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○

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

If yes:

7.9.1 What support did they receive?

Paid carers	○
Informal carers	○
Paid and informal carers	○
Paid care services unavailable	○
Patient refused	○

7.9.3 At point of discharge, how many visits per day did the patient require?

One ○ Two ○ Three ○ Four ○ 24 hour care ○
Not known ○

7.9.4 How many carers? One carer ○ Two carers ○ 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. At the point of discharge, was the patient provided with the contact details of a named healthcare professional who can provide further information, support and advice, as and when needed?
Yes ○ No ○

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?
(not available to answer on webtool for teams in Northern Ireland)

7.15. Please state if the patient gave consent for their information to be included in research using SSNAP data?
(not available to answer on webtool for teams in Northern Ireland)

Changes to the SSNAP Core Inpatient Dataset

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?' *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 2015	– 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?'

4.0.0	01 Dec 2017	– 2.1.7 - remove validation: Validation Change: "Yes" is available even if patient is not in AF prior to this admission i.e. if 2.1.3 "Atrial Fibrillation" = No then 2.1.7 answer options are not greyed out. – 2.1.7a - New question and validation – 2.1.7b - New question and validation – 2.1.8 - New question and validation – 2.8 - New question and validation – 2.9 - New question and validation – 2.9.1 - New question and validation – 2.9.2 - New question and validation – 2.9.3 - New question and validation – 2.9.4 - New question and validation – 2.9.5 - New question and validation – 2.9.6 - New question and validation – 2.9.7 - New question and validation – 2.9.8 - New question and validation – 2.9.9 - New question and validation – 2.9.10 - New question and validation – 2.9.11 - New question and validation – 2.9.12 - New question and validation – 2.9.13 - New question and validation – 2.9.14 - New question and validation – 2.9.15 - New question and validation – 2.12 - New question and validation – 2.13 - New question and validation – 2.14 - New question and validation – 2.14a - New question and validation – 2.15 - New question and validation – 2.15.1 - New question and validation – 3.3a - New question and validation – 3.3b - New question and validation – 3.3c - Change to previous question 3.3
5.0.0	01 Jul 2021	– 2.1.1f – Addition sub question for 2.1: 'Dementia' – 2.4.1 – New question and validation: 'Modality of first brain imaging after stroke:' – 2.4.2 – New question: 'Was artificial intelligence (AI) used to support the interpretation of the first brain imaging?' – 2.11.0 – New question and validation: 'Was patient referred for intra-arterial intervention for acute stroke?' – 2.11.0a – New question: 'Date and time of initial referral for intra-arterial intervention' – 2.11.0b – New question: 'Date and time ambulance transfer requested' – 2.11.0c – New question: 'Date and time ambulance departed referring hospital' – 2.11.0d – New question and validation: 'Was a helicopter used?' – 2.11a – New sub question: 'If no, reason a procedure (arterial puncture) not begun' – 2.11.ci – New question: 'Was the perfusion' – 2.11.3 – Additional answer options: 'General anaesthetic from the outset; General anaesthetic by conversion from lesser anaesthesia' – 2.11.3a – New question and validation: 'Specialty of anaesthetist (if present)' – 2.11.4 –New answer option: 'Training fellow/specialty trainee' – 2.11.4a – New question: 'What was the specialty of the second operator?' – 2.11.4b – New question: 'What intervention lab was used' – 2.11.4c – New question and validation: 'If monoplane, why?' – 2.11.5 – Question modified from 'Were any of the following used?' to 'Which method(s) were used to reopen the culprit occlusion?' – 2.11.6bi – New sub question and validation: 'Deployment of device not performed because' – 2.11.6d – New question and validation: 'Were any of the following procedures required?' – 2.11.6e – New question and validation: 'How many passes were required?' – 2.11.7 – New question with sub questions and validation:' Were there any procedural complications?' – 2.11.8 – New answer options: '2c' – 2.11.9 – New answer options: 'Stroke unit at receiving site; Stroke unit at referring site' – 2.11.9a – New sub question and validation: 'If transferred to ICU or HDU, what was the indication for high-level care?' – 3.9 – New question: '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?'

		– 4.6.1 – New question and validation: 'How many of the total therapy minutes were provided by a rehabilitation assistant?' – 4.6.2 – New question and validation: 'How many of the total therapy minutes were delivered by video/teletherapy?' – 4.8 – New question: 'Was the patient considered to require nursing care any point in this admission?' – 4.8.1 – New question: 'If yes, at what date was the patient no longer considered to require this care?' – 4.8.2 – New question: 'On how many days did the patient receive nursing care across their total stay in this hospital/team?' – 4.8.3 – New question: 'How many minutes of nursing care in total did the patient receive during their stay in this hospital/team?' – 4.9 – New question: 'Date patient screened for mood using a validated tool' – 4.9.1 – New question: 'If not screened, what was the reason?' – 4.10 – New question: 'Date patient screened for cognition using a simple standardised measure?' – 4.10.1 – New question: 'If not screened, what was the reason?' – 7.13 – New question: 'Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?' – 7.13.1 – New question: 'If Yes, was COVID-19' – 7.14 – New question and validation: '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?' – 8.8 – New question: 'Employment status prior to stroke' – 8.8.1 – New question: 'Employment status currently' – 8.9 – New question: 'EQ5D-5L score six months after stroke'
5.1.1	10 Oct 2022	– 3.3a – question wording update to match webtool, delayed from 2017 – 3.3c – question wording update to match webtool, delayed from 2017
6.0.0	01 Oct 2024	– Introduction updated as core dataset split into three core datasets: (1) inpatient, (2) community, and (3) six months – 1.6 – answer option added: 'Indeterminate' (Gender) – 1.8 – answer options updated (Ethnicity) – 1.12.3 – new question (Was pre-hospital video triage used for this patient?) – 2.1.1e – word 'Previous' added to question (Did the patient have any of the following co-morbidities prior to this admission? Previous stroke/TIA) – 2.4.1 - question removed (modality of first brain imaging) – 2.4a - question added (What brain imaging was performed on the patient's first visit to the imaging department?) – 2.4b – question added (Date and time of all brain imaging within 24 hours of clock start) – 2.5.1 - question added (Was the infarction a Large Vessel Occlusion?) – 2.5.2 - question added (How was the Large Vessel Occlusion determined?) – 2.7.1 - question added (What thrombolysis agent was used?) – 2.11.2 – question wording updated to What further brain imaging was performed at the receiving site prior to the intra-arterial intervention? (from What brain imaging technique(s) was carried out prior to the intra-arterial intervention?) – 2.11.9a – question removed (If transferred to ICU or HDU, what was the indication for high-level care?) – 2.11.10 – question added (Where was the target occlusion?) – 2.13.1 - question added (If blood pressure lowering treatment not given, what was the reason?) – 2.15.1 – answer option removed: DOAC antidote (What reversal agent was given?) – 2.15.1 – answer option added: Idarucizumab (What reversal agent was given?) – 2.15.1 – answer option added: Andexanet alfa (What reversal agent was given?) – 2.15.3 - question added (If anticoagulant reversal not given, what was the reason?) – 2.16 - question added (Did the patient have a neurosurgery consultation?) – 2.16.1 - question added (Was the patient transferred for neurosurgery?) – 2.17 – question added (What was the maximum diameter (in any direction) of the intracerebral haematoma on the first brain imaging?) – 3.2.0 – question added (Date/time first assessed (in person) by a stroke skilled clinician) – 4.4-4.6.2 – rehabilitation data collection changed from Physiotherapy, Occupational therapy, Speech and language therapy, and Psychology to Motor function, Psychological function, Communication/swallowing and Other – 4.6.1 – question removed (At what date was the patient no longer considered to require this therapy?)

		– 4.6.2 – question added (How many of these minutes were delivered in a group session?). 4.6.2 in the core dataset 5.1.1 was available for community teams only and was: How many of the total therapy minutes were delivered by video/teletherapy? – 4.7.1 – answer option removed (Patient considered to have no rehabilitation potential) – 5.1 – question removed (What was the patient's worst level of consciousness in the first 7 days following initial admission for stroke?) – 6.6.1 - words 'If yes' removed from question (Date patient saw a dietitian) – 6.8 – question wording updated to Date patient screened for cognition using a validated tool (from Date patient screened for cognition using a simple standardised measure) – 6.11.1 – question removed (If yes, what date was intermittent pneumatic compression first applied?) – 6.11.2 – question removed (If yes, what date was intermittent pneumatic compression finally removed?) – 6.12 - question added (Date/time first assessed by a Psychologist) – 6.12.1 - question added (If no assessment, what was the reason?) – 6.13 – question added (Date patient screened for visual impairment using a standardised tool) – 6.13.1 – question added (If not screened, what was the reason?) – 6.14 – question added (Date/time first assessed by an Orthoptist) – 6.14.1 – question added (If no assessment, what was the reason?) – 6.15 – question added (What was the patient's employment status prior to stroke?) – 7.1.4 - question added (If discharged to ESD/community team, where is the patient living?) – 7.8.1 – question added (Was the patient discharged with a combined ESD-CRT service?) – 7.9 – word 'personal' added to question (Did the patient require help with personal activities of daily living (ADL)?) – 7.9.2 – question removed (At point of discharge, how many visits per week were social services going to provide?) – 7.9.3 – question added (At point of discharge, how many visits per day did the patient require?) – 7.9.4 - question added (How many carers?) – 7.12 – question wording updated to At point of discharge, was the patient provided with the contact details of a named healthcare professional who can provide further information, support and advice, as and when needed? (from Is there documentation of a named person for the patient and/or carer to contact after discharge?) – 7.13 – question removed (Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?) – 7.13.1 – question removed (If yes, was COVID-19:) – 7.15 – question added (Please state if the patient gave consent for their information to be included in research using SSNAP data?)