SSNAP | Sentinel Stroke National Audit Programme

KING'S College LONDON

SSNAP Core Inpatient 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
6.0.0	01/10/2024	Updated official core dataset help notes with additional questions

Version	Major amendments	Minor amendments	Clarifications/Additional information
1.1.2	None	Exclusion criteria 1.12.2, 8.1	1.11 , 1.11.3, 1.1, 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,
6.0.0	4.4-4.6.2	Introduction Questions: 1.6, 1.8, 2.1,2.11.2, 2.15.1, 6.8, 7.9	Additional questions: 1.12.3, 2.4a, 2.4b, 2.5.1, 2.5.2, 2.7.1, 2.11.10, 2.13.1, 2.15.3, 2.16, 2.16.1, 2.17, 3.2.0, 4.6.2, 6.12, 6.12.1, 6.13. 6.13.1, 6.14, 7.1.4, 7.8.1, 7.9.3, 7.9.4, 7.12, 7.15 Questions 2.4.1, 2.11.9a, 4.6.1, 5.1, 7.9.2, 7.13, 7.13.1 removed

If the help note for a question has been clarified between versions 5.1.1 and 6.0.0, the question is highlighted blue in the table below, and the clarification underlined.

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 across 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 2023.

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/About/Our-governance/Oversight.aspx.

The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients and the public on how well stroke care is being delivered.

SSNAP

- 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 2026.

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.

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 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. These help notes refer to the **Core Inpatient Dataset.**

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.
1.6	Gender	Male; Female; Indeterminate	Indeterminate should be chosen if the patient is unable to be classified as either male or female. It should not be used in place of 'Not known'.
1.7	Postcode of usual address	First box: 2-4 alphanumerics Second box: 3 alphanumerics. The full postcode of the patient's normal place of residence.	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. For patients from overseas or has no fixed abode please enter the following into the postcode field: ZZ11 1ZZ.

Question no	Question	Answer options	Guidance / definitions
1.8	Ethnicity	Either code A-Z OR "Not Known" These are the categories as specified by NHS and HSCIC: **England and Wales** <u>White</u> A British B Irish C Any other White background <u>Mixed</u> D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background <u>Asian or Asian British</u> H Indian J Pakistani K Bangladeshi L Any other Asian background <u>Black or Black British</u> M Caribbean N African	The ethnicity of a person, as specified by the person. 'Not stated' The person had been asked and had declined either because of refusal or genuine inability to choose. '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.

Question no	Question	Answer options	Guidance / definitions
		P Any other Black background <u>Other Ethnic Groups</u> R Chinese S Any other ethnic group Z Not stated 99 Not known	
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 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.

Question no	Question	Answer options	Guidance / definitions
			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.
1.11	Date/time of onset/awareness of symptoms	dd/mm/yyyy hh:mm	If best estimate or stroke during sleep (for 1.11.1), the date should be the date last known to be well. The time can be the time last known to be well or left blank if a best estimate cannot be made (and not known entered for 1.11.2). However, for inpatients who had a stroke during sleep, enter the date/ time the patient first woke up (cannot be not known for inpatient, and should not be time last well, as for inpatient strokes, standards are measured from time of onset).
1.11.1	The date given is:	Precise; Best estimate; Stroke during sleep	For inpatients who had a stroke during sleep, enter the date/ time the patient first woke up.
1.11.2	The time given is:	Precise; Best estimate; Not known	*Cannot be "Precise" unless 1.11.1 = "Precise"* *Cannot be "Not Known" if 1.10="Yes"* For inpatients who had a stroke during sleep, enter the date/ time the patient first woke up.
1.12	Did the patient arrive by ambulance?	Yes; No	*If 1.10 = Yes then 1.12 will default to No*

<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>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 12 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="5">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>
<tr><td>3. Case reference (twelve-character).</td></tr>
<tr><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>
</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>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>1.12.3</td><td>Was pre-hospital video triage used for this patient?</td><td>Yes; No</td><td>Available if 1.12 = Yes
Pre-hospital video triage is a specific intervention involving video assessment of the patient either in their home or enroute to hospital to determine the appropriate pathway for the patient. It does not include verbal assessment or a discussion on audio or video purely between the ambulance personnel or ambulance control and the receiving site.</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 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	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	Previous 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 2.1.1c is yes 'No but' for the atrial fibrillation can only mean 'no - but for good reason' - which means the clinician judges that the individual patient risk of bleeding complication (related to anticoagulant or antiplatelet therapy) outweighs benefit in stroke risk reduction.
2.1.7	Was the patient on anticoagulant medication prior to admission?	Yes; No; No but	*Yes is available even if patient is not in AF prior to this admission.* To select 'No but' in answer to this question means that it is recorded that a prescriber judged the patient's risk of a bleeding complication to outweigh the benefit in stroke risk reduction. If this cannot be confirmed then the answer to this question is 'No'.

Question no	Question	Answer options	Guidance / definitions
			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 hospital (if inpatient, INR at the time of stroke onset)?	Value range: 0.0 – 10.00 or 'INR not checked' or 'Greater than 10'	*Available if 2.1.7(a) = 'Vitamin K antagonist'* If inpatient, INR at the time of stroke onset should be used. International normalized ratio (INR) is a blood test to assess the anticoagulant effect of Warfarin and other Vitamin K antagonists. Many patients have their most recent INR recorded in their yellow anticoagulant book issued by the prescriber. If the INR is recorded is 'greater than 10' then select the 'Greater than 10' radio button.

Question no	Question	Answer options	Guidance / definitions
2.1.8	Was a new diagnosis of AF made on admission?	Yes; No	*Not available if AF is selected as comorbidity for 2.1.1c.* 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 not be filled in for either a direct entry or import.	National Institute for Health Stroke Scale (NIHSS) on arrival is collected on first contact with the stroke team. All clinicians should have received training in NIHSS. Further guidance is available here: https://www.mdcalc.com/nih-stroke-scale-score-nihss 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).

Question no	Question	Answer options	Guidance / definitions
			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. 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.

Question no	Question	Answer options	Guidance / definitions
			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 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).

Question no	Question	Answer options	Guidance / definitions
			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. 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

Question no	Question	Answer options	Guidance / definitions
			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. 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

Question no	Question	Answer options	Guidance / definitions
			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 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.

Question no	Question	Answer options	Guidance / definitions
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 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 anosognosia 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

Question no	Question	Answer options	Guidance / definitions
			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. 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.
2.4a	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	*Unavailable if 2.4 = "Not imaged"* *Select all that apply* Select all scans that were performed during the patient's first visit to the clinical imaging/radiology department. If multiple scans were carried out during the patient's first visit to the Radiology Department/scanner, select all scans carried out during this visit, e.g. if the patient had a plain CT followed by a CT angiogram (CTA) followed by a CT perfusion (CTP) on the same visit to the scanner, select 'Plain/non-contrast CT', 'CT intracranial angiogram' and 'CT perfusion' for this question.

Question no	Question	Answer options	Guidance / definitions
			You are unable to select both MRI and CT imaging options for this question, choose the scan type patient received first.
2.4b	Date and time of all brain imaging within 24 hours of first scan:		*This is an opportunity to record the date/time of additional scans (only if the scan was not performed during the first visit)*
2.4b.1	Plain/non-contrast CT	dd/mm/yyyy hh:mm OR Not performed	*Unavailable if 2.4 = "Not imaged"* If this scan was not performed during the patient's first visit to the clinical imaging/radiology department, enter the date and time the scan was subsequently performed.
2.4b.2	CT intracranial angiogram	dd/mm/yyyy hh:mm OR Not performed	*Unavailable if 2.4 = "Not imaged"* If this scan was not performed during the patient's first visit to the clinical imaging/radiology department, enter the date and time the scan was subsequently performed.
2.4b.3	CT Perfusion	dd/mm/yyyy hh:mm OR Not performed	*Unavailable if 2.4 = "Not imaged"* If this scan was not performed during the patient's first visit to the clinical imaging/radiology department, enter the date and time the scan was subsequently performed.
2.4b.4	Plain/non-contrast MRI	dd/mm/yyyy hh:mm OR Not performed	*Unavailable if 2.4 = "Not imaged"* If this scan was not performed during the patient's first visit to the clinical imaging/radiology department, enter the date and time the scan was subsequently performed.
2.4b.5	Contrast-enhanced MRA	dd/mm/yyyy hh:mm OR Not performed	*Unavailable if 2.4 = "Not imaged"* If this scan was not performed during the patient's first visit to the clinical imaging/radiology department, enter the date and time the scan was subsequently performed.
2.4b.6	MR perfusion	dd/mm/yyyy hh:mm OR Not performed	*Unavailable if 2.4 = "Not imaged"* If this scan was not performed during the patient's first visit to the clinical imaging/radiology department, enter the date and time the scan was subsequently performed.

Question no	Question	Answer options	Guidance / definitions
2.4b.7	ASPECTS score	0-10 or “Haemorrhagic stroke” or “Not known”	*Unavailable if Plain/non-contrast CT not performe*d
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”* 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.
2.5.1	Was the infarction a Large Vessel Occlusion?	Yes; No	*LVO is defined as an occlusion of either the first segment of the middle cerebral artery (M1), the terminal portion of the internal carotid artery (Terminal ICA) or the proximal portion of the second segment of the middle cerebral artery (M2).*
2.5.2	How was the Large Vessel Occlusion determined?	From an angiogram; Clinically without an angiogram	*The preferred method for determining a LVO is from an angiogram. This should be selected if LVO is diagnosed directly from angiogram.* *Clinically without an angiogram should only be selected when the patient presented with an LVO syndrome either without an angiogram OR despite no LVO being evident on an angiogram*
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.

Question no	Question	Answer options	Guidance / definitions
2.6.2	If no but, please select the reasons:		Select all the reasons which apply 2.6.2.1 – 2.6.2.10.
2.6.2.1	Haemorrhagic stroke		*Auto selected if 2.5=PIH.*
2.6.2.2	Arrived outside thrombolysis time window		*Available if 2.6 = No but* This means outside of the window of time when patient can be safely given thrombolysis, not the days and times when thrombolysis is provided by a team, which if this is the reason is outside of service hours.
2.6.2.3	Stroke too mild or too severe		The RCP Guidelines were updated following the International Stroke Trial 3 (IST3). The NIHSS >25 was dropped as a reason for precluding thrombolysis and therefore stroke too severe cannot be the sole "no but" reason.
2.6.2.4	Contraindicated medication		
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		Frailty should be included as a 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 2.4 and cannot be more than 12 hours after 1.11 or 1.13* *Available if 2.6 = Yes*
2.7.1	What thrombolysis agent was used?	Alteplase; Tenecteplase	*Available if 2.6 = Yes*

Question no	Question	Answer options	Guidance / definitions
2.8	Was there evidence of cerebral haemorrhage on brain imaging after the patient received thrombolysis/thrombectomy?	Yes; No	*Available if 2.6 or 2.11 = 'Yes'.* Record any report of intracranial haemorrhage (bleeding within the skull or brain) following treatment Note: Data from this question combined with Q2.9 will be used to measure the incidence of symptomatic intracranial haemorrhage after thrombolysis/thrombectomy.
2.9	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.* All clinicians should have received training in NIHSS. Further guidance is available here: https://www.mdcalc.com/nih-stroke-scale-score-nihss 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.
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"	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.

Question no	Question	Answer options	Guidance / definitions
2.10.1	If screening was not performed within 4 hours, what was the reason?	Not known; Organisational Reasons; Patient Refused; 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) 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

Question no	Question	Answer options	Guidance / definitions
			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"* *To be answered by referring team* 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"* *To be answered by referring 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"* *To be answered by referring team* If a helicopter was used, this should be the date and time the helicopter transfer departed from referring hospital.
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 referring team*

Question no	Question	Answer options	Guidance / definitions
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).
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	*Available if 2.11 is 'Yes'* Please answer *'Yes'* if the patient was randomised for an intra-arterial intervention as part of a randomised clinical trial.
2.11.2	What further brain imaging was performed at the receiving site prior to the intra-arterial intervention?		*Available if 2.11 is 'Yes' and if 2.11.0 is 'Yes, accepted at another team'* *Refers to further brain imaging performed by the thrombectomy-performing team*
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 scan:	CT; MR; Both	*Available if 2.11.2c is 'Yes'*

Question no	Question	Answer options	Guidance / definitions
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	*Available if 2.11 is 'Yes'* Please select the response that best reflects the anaesthesia used for the majority of the intervention.
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	*Available if 2.11 is 'Yes'*

Question no	Question	Answer options	Guidance / definitions
a	What was the speciality of the second operator?	Interventional neuroradiologist; Cardiologist; Interventional radiologist; Training fellow/ speciality trainee; Other; No second operator	*Available if 2.11 is 'Yes'*
b	What intervention lab was used	Biplane; Monoplane	*Available if 2.11 is 'Yes'*
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?		*Available if 2.11 is 'Yes'*
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:		*Available if 2.11 is 'Yes'*
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	
	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	
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	

<table>
<tr><th>Question no</th><th>Question</th><th>Answer options</th><th>Guidance / definitions</th></tr>
<tr><td></td><td>c. Intracerebral haemorrhage</td><td>Yes; No</td><td></td></tr>
<tr><td></td><td>d. Subarachnoid/intraventricular haemorrhage</td><td>Yes; No</td><td></td></tr>
<tr><td></td><td>e. Arterial dissection or perforation</td><td>Yes; No</td><td></td></tr>
<tr><td></td><td>f. Vasospasm</td><td>Yes; No</td><td></td></tr>
<tr><td></td><td>g. Other</td><td>Yes; No</td><td></td></tr>
<tr><td>2.11.8</td><td>Angiographic appearance of culprit vessel and result assessed by operator (modified TICI score):</td><td></td><td>Available if 2.11 is ‘Yes’</td></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>
</table>

Question no	Question	Answer options	Guidance / definitions
b	Post-intervention:	0; 1; 2a; 2b; 2c; 3	Select one value for the Modified TICI score with 2c
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	*Available if 2.11 is 'Yes'* Where the patient was first transferred from the angiography suite or recovery area.
2.11.10	Where was the target occlusion?	Anterior/carotid territory; Posterior/vertebrobasilar territory	*Available if 2.11 is 'Yes'*
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 1.11 If onset is not known, date/time of blood pressure lowering must be on the same day or next day of 1.11.

Question no	Question	Answer options	Guidance / definitions
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	*Available if 2.13 = 'Not 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 24 h	*Not available if 2.13 is 'Not given'* *Date/Time must be 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; Idarucizumab; Andexanet alfa; FFP; Protamine; Vitamin K	*Available if 2.15 = 'Yes'. Select all that apply.* PCC = Prothrombin Complex Concentrate 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.
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	*Available if 2.15 = 'No'*
2.16	Did the patient have a neurosurgery consultation?	Yes; No	*Available if 2.5 = PIH* *Neurosurgery consultation can be in person or via telephone or online*
2.16.1	Was the patient transferred for neurosurgery?	Yes; No	*Available if 2.5 = PIH* *Being transferred for neurosurgery is irrespective of whether surgery was ultimately performed.* *For a neurosurgical centre it would include the patient going to a neurosurgical ward rather than a stroke unit.*
2.17	What was the maximum diameter (in any direction) of the intracerebral haematoma on the first brain imaging?	0.1-20.0cm	*Available if 2.5 = PIH*
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 after clock start but then recovers:

Question no	Question	Answer options	Guidance / definitions
			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 (3.1 = 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* 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 for their end of life care?	Yes; No	*Available if 3.1 = Yes* This should be a documented end of life care plan, which may include referral to the palliative care team or the use of a care bundle such as AMBER or Rapid Discharge Home to Die pathway
3.2.0	Date/time first assessed (in person) by a stroke skilled clinician	Either date/time OR "No assessment in first 72 hours"	'Initial clinical assessment' is an in-person evaluation of the patient including emergency imaging and hyperacute treatments for infarction or haemorrhage. A stroke skilled clinician is a trust-designated clinician from any background discipline 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, blood pressure lowering treatment and anticoagulant reversal.

Question no	Question	Answer options	Guidance / definitions
			Triage or screening assessments by a clinician not trained or authorised to deliver these treatments do not qualify under this standard. If the initial assessment is performed by a registered nurse or by a stroke consultant, this date and time may be the same as the date and time given in 3.2 or 3.3a. Please do not record any prehospital telemedicine/video triage assessments performed as part of an ambulance pre alert.
3.2	Date/time first assessed by nurse trained in stroke management	Either date/time OR "No assessment in first 72 hours"	A nurse trained in 'stroke management' would have stroke specific management experience i.e. can check for deterioration of symptoms and take necessary steps. Perhaps (s)he is trained in transfers.
3.3a	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. 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). A 'suitable' consultant in stroke is defined by the stroke specialist standards (appendix a, page 8). Consultant level staff from nursing or therapy provided they have the appropriate skills can replace medical consultant. https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2019/03/4-priority-clinical-standards-applied-to-stroke-services.pdf A registrar would NOT meet these requirements. Please do not record any prehospital telemedicine/video triage assessments performed as part of an ambulance pre alert.

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)	*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"	*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: 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-

Question no	Question	Answer options	Guidance / definitions
			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?	Not known; Organisational Reasons; Patient Refused; 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"	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 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 direct assessment i.e., not an observer. This may not necessarily be the first contact with the patient by therapy.
3.5.1	If assessment was not performed within 72 hours, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell; 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 to have any problems requiring OT input. Therapy assistants are able to identify patients as having no relevant deficit. 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"	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 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 direct assessment i.e., not an observer. This may not necessarily be the first contact with the patient by therapy.
3.6.1	If assessment was not performed within 72 hours, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell; 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 to have any problems requiring physiotherapy input. Therapy assistants are able to identify patients as having no relevant deficit.
3.7	Date/time communication first assessed by Speech and Language Therapist (SALT)	Either date/time OR "No assessment in first 72 hours"	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 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 direct assessment i.e., not an observer. This may not necessarily be the first contact with the patient by therapy.

Question no	Question	Answer options	Guidance / definitions
3.7.1	If assessment was not performed within 72 hours, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell; 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 to have any communication problems requiring SALT input. Therapy assistants are able to identify patients as having no relevant deficit.
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 or a professional trained in dysphagia assessment within 72 hours of clock start. If not, you can answer this question in section 6 of the dataset. A professional trained in dysphagia assessment refers to a registered professional who has achieved Level 5 Specialist Assessment and Management on the Eating, Drinking and Swallowing Competency Framework (RCSLT), or equivalent.
3.8.1	If assessment was not performed within 72 hours, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell; Patient passed swallow screen	*Unavailable if date is entered for 3.8 Cannot enter "patient passed swallow screening" if 3.4= patient not screened in first 72 hours* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate an assessment by clinical staff for the period up until the assessment eventually took place. Organisational reasons mean any issues with the service which meant that the assessment was not performed within 72 hours e.g. unavailability of staff.

Question no	Question	Answer options	Guidance / definitions
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". 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'
For further details on how to answer the questions in section 4 please see the appendix.			
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 This is the date/time the patient arrived with your 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	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
4.4	Was the patient considered to require this care or treatment at any point in this admission?	Yes; No for each of: Motor function Psychological function Communication/Swallowing Other	This collects whether a patient was considered to have any identified needs under each of the categories of therapy or care at any point during their total stay under the care of your team. For each therapy/care category, if a patient is assessed and does not need any further therapy/care, then the patient was not considered to require this therapy/care at any point in this admission. Answer 'No'.

Question no	Question	Answer options	Guidance / definitions
			If a patient is assessed and requires further therapy/care (even if they do not receive further therapy/care), answer 'Yes'. If the patient receives no further therapy/care, record 0 days.
4.5	On how many days did the patient receive this care/treatment across their total stay in this hospital/team?	Integer (for each of Motor function, Psychological function, Communication/Swallowing, Other)	*Available if 4.4 is Yes.* *Cannot be more than the number of days they were in this service.* This is the total number of days on which the patient received each type of therapy/care from the day their care became the responsibility of this team to their discharge date from that team. This is not the number of sessions, but calendar days. It is collected separately for each team and therapy type.
4.6	How many minutes of this care/treatment in total did the patient receive during their stay in this hospital/team?	Integer (for each of Motor function, Psychological function Communication/Swallowing 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 patient received while in your care. The unit of measurement is minutes. The number of minutes must be a whole number. All minutes for any initial assessment should be included under Other. Any further domain-specific assessments should go under their relevant therapy/care type, i.e. a cognition assessment should go under psychological function.
4.6a	How many of these minutes were delivered by a rehabilitation assistant?	Integer (for each of Motor function Psychological function Communication/Swallowing Other)	This is the number of the total minutes recorded in 4.6 that were provided specifically by a non-registered rehabilitation or therapy assistant or support worker working independently. 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 across staff groups).

Question no	Question	Answer options	Guidance / definitions
			If a rehabilitation assistant works on two different categories of rehabilitation during a 60 minutes session, record the number of minutes for each category (e.g. 30 minutes for motor function, 30 minutes for communication). Please refer to patient notes to accurately determine the split. Therapy provided by student therapists should be recorded as assistant delivered (unless jointly delivered with qualified member of staff- see appendix).
4.6b	How many of these minutes were delivered in a group session?	Integer (for each of Motor function Psychological function Communication/Swallowing Other)	This is the number of the total therapy minutes recorded in 4.6 that were provided specifically in a group session. This is any session where there is more than one patient working towards a similar task/group aim. This only includes groups where patients are working specifically towards a targeted therapy goal associated with defined categories as above. Groups outside of these categories (such as those aimed at reducing occupational deprivation) should not be included.
4.7	Date rehabilitation goals agreed	Either date OR "No goals"	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?	Patient refused; Organisational reasons; Patient medically unwell for entire admission; Patient has no impairments; Not known	*Available if 4.7 is Not known* Organisational reasons mean any issues with the service which meant that the no goals were set e.g. unavailability of staff. Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to agree rehabilitation goals 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).

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	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	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"	*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?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission; Patient had no relevant deficit	*Available if 6.1= "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the assessment 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.

Question no	Question	Answer options	Guidance / definitions
			Patient had no relevant deficit should be answered if the patient was not considered to have any problems requiring occupational therapy input. Therapy assistants are able to identify patients as having no relevant deficit.
6.2	Date/time first assessed by a Physiotherapist	Either date/time OR "No assessment by discharge"	*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?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission; 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 assessment 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 to have any problems requiring physiotherapy input. Therapy assistants are able to identify patients as having no relevant deficit.

Question no	Question	Answer options	Guidance / definitions
6.3	Date/time communication first assessed by Speech and Language Therapist?	Either date/time OR "No assessment by discharge"	*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?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission; 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 assessment 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 to have any problems requiring speech and language therapy input. Therapy assistants are able to identify patients as having no relevant deficit.

Question no	Question	Answer options	Guidance / definitions
6.4	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 by discharge"	*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. A professional trained in dysphagia assessment refers to a registered professional who has achieved Level 5 Specialist Assessment and Management on the Eating, Drinking and Swallowing Competency Framework (RCSLT), or equivalent. If not, this question should be answered in section 3 of the dataset.
6.4.1	If no assessment, what was the reason?	Not known; Organisational Reasons; Patient Refused; 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 assessment 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?	Not known; Organisational Reasons; Patient Refused; Patient continent	*Available if 6.5= "No plan"* Organisational reasons mean any issues with the service which meant that a plan was not drawn up 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. The nutrition screening tool used should identify all patients with dysphagia as being at high risk of malnutrition and therefore requiring dietetic assessment. 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 dietitian when this was required.
6.6.1	Date patient saw a dietitian	Either date OR "Not seen by a dietitian"	*Available if 6.6=Yes or Not screened*
6.7	Date patient screened for mood using a validated tool	Either date OR "Not screened"	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.
6.7.1	If not screened, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission	*Unavailable if date is entered for 6.7* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate mood screening by clinical staff. Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. There is no “Patient had no relevant deficit” answer option as this is a screening, and the screening is required to determine if the patient had a deficit.

Question no	Question	Answer options	Guidance / definitions
6.8	Date patient screened for cognition using a validated tool?	Either date OR "Not screened"	Cognition measure is one which has been approved for use within the trust/ health board such as MOCA/OCS. A validated tool is one with evidenced validity and efficacy for use in stroke. Locally developed screening tools are not applicable. Screening via assessment in function for those deemed unable to participate in a screen is 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?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission	*Unavailable if date is entered for 6.8* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate cognition screening by clinical staff. Organisational reasons mean any issues with the service which meant that the screening was not performed by discharge e.g. unavailability of staff. There is no “Patient had no relevant deficit” answer option as this is a screening, and the screening is required to determine if the patient had a deficit.
6.9	Has it been decided by discharge that the patient is for palliative care?	Yes; No	*Unavailable if 3.1 = Yes*

Question no	Question	Answer options	Guidance / definitions
6.9.1	Date of palliative care decision	dd/mm/yyyy	*Date must be more than 72 hours after 1.13* *Available if 6.9 = Yes* The date 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. 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.
6.12	Date/time first assessed by a Psychologist	dd/mm/yyyy hh:mm OR "No assessment by discharge"	A psychologist is defined a clinical psychologist or clinical neuropsychologist with stroke expertise

Question no	Question	Answer options	Guidance / definitions
6.12.1	If no assessment, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission; Patient had no relevant deficit;	*Available if 6.12 = "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the assessment 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, after screening by an appropriately skilled clinician, the patient was not considered to have any relevant impairment requiring psychologist input.
6.13	Date patient screened for visual impairment using a standardised tool?	dd/mm/yyyy OR "Not screened"	A standardised tool is one that is completed the same way by all users, covering all required domains of impairment and activity limitation. A published screen such as VISA, or a locally developed tool, agreed by your orthoptist dept for use with all patients, by staff with appropriate training are applicable.
6.13.1	If not screened, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission	*Available if 6.13 = "Not screened"* Patient medically unwell should be answered if the patient was unconscious or deemed to be unable to tolerate vision 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.

Question no	Question	Answer options	Guidance / definitions
6.14.	Date/time first assessed by an Orthoptist	dd/mm/yyyy hh:mm OR "No assessment by discharge"	Please make every effort to establish date and time of assessment, even if this has been completed in an outpatient/clinic setting
6.14.1	If no assessment, what was the reason?	Not known; Organisational Reasons; Patient Refused; Patient medically unwell for entire admission; Patient had no relevant deficit; Scheduled outpatient appointment	*Available if 6.14 = "No assessment by discharge"* Organisational reasons mean any issues with the service which meant that the assessment 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, after screening by an appropriately skilled clinician, the patient was not considered to have any relevant impairment requiring orthoptic input.
6.15	What was the patient's employment status prior to stroke?	Working full-time; Working part-time; Retired; Studying or training; Unemployed; Other	Prior to stroke = the period immediately 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
7.1	The patient:	Died; Was discharged to a care home; Was discharged home; Was discharged to somewhere else;	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

Question no	Question	Answer options	Guidance / definitions
		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	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). Please select ESD/Community stroke team for integrated community stroke services (ICSS). 'Was transferred to an inpatient/ESD/community team' should only be selected if the inpatient/ESD/community team the patient was transferred to is set up on the SSNAP webtool to receive SSNAP record transfers. If the team is not set up on SSNAP then 'Was transferred to an inpatient care team, not participating in SSNAP' or 'Was transferred to an ESD/community team, not 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	*Available if 7.1 is "Died in hospital"*

Question no	Question	Answer options	Guidance / definitions
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: If a team is no longer accepting records on SSNAP OR The team has been set up recently and is not currently participating 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.
7.1.4	If discharged to ESD/community team, where is the patient living?	Home; Care home; Other	*Available if 7.1 = "*Was transferred to an ESD/community team" or "Was transferred to an ESD/community team, not participating in SSNAP"
7.2	Date/time of discharge from stroke unit	dd/mm/yyyy / hh:mm	*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	*Unavailable if 7.1 = "Died in hospital"* *Cannot be before any dates/times in sections 1-6*

Question no	Question	Answer options	Guidance / definitions
7.3.1	Date patient considered by the multidisciplinary team to no longer require inpatient care?	dd/mm/yyyy	*Cannot be after 7.3* This captures when the MDT feel the patient no longer requires MDT acute inpatient stroke unit care, but the patient is unable to leave hospital for external reasons for example, care cannot be sought, or housing issues. *Unavailable if Q7.1 is 'Died' or 'Was transferred to another inpatient care team' or 'Was transferred to another inpatient care team, not participating on SSNAP'* *For non-transferred patients, if Q1.10 is 'No', cannot be before Q1.13 and if Q1.10 'Yes', cannot be before Q1.11* *For transferred patients, cannot be before Q4.1*
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

Question no	Question	Answer options	Guidance / definitions
			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" or 7.1.4 is "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" or 7.1.4 is "Home"*
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" OR "Was transferred to another inpatient care team, not participating on SSNAP"* An Early Supported Discharge (ESD) service provides ESD only to eligible patients. ESD is an intervention delivered by a coordinated, multidisciplinary team that facilitates the earlier transfer of care from hospital into the community and provides responsive (within 24 hours) and intensive stroke rehabilitation in the patient's place of residence over a fixed, time-limited period (e.g. 6 weeks). A stroke/neurology specific team is one which treats stroke patients or stroke and neurology patients and staff have specific knowledge and practical experience of stroke. 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 and 7.8.1.

Question no	Question	Answer options	Guidance / definitions
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" OR "Was transferred to another inpatient care team, not participating on SSNAP"* A Community Rehabilitation Team / Service (CRT) is a multi-disciplinary team that provides community stroke rehabilitation to stroke patients requiring a lower level of intensity, condition, disability or case management. This may be following hospital discharge, after a patient has been discharged from an ESD team or at any point post stroke where rehabilitation needs are identified. The intensity or duration of this service is determined by patient need. A stroke/neurology specific team is one which treats stroke patients or stroke and neurology patients and staff have specific knowledge and practical experience of stroke. 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 and 7.8.1.
7.8.1	Was the patient discharged with a combined ESD-CRT service?	Yes, stroke/neurology specific; Yes, non-specialist; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team" OR "Was transferred to another inpatient care team, not participating on SSNAP"* Combined ESD-CRT refers to a service that provides both ESD and CRT (as outlined above in 7.7 and 7.8) as part of an Integrated Community Stroke Service (ICSS). If a patient is discharged to a stroke/neuro-specific combined ESD-CRT service, please answer "Yes, stroke/neurology specific" to both 7.8.1 and "No" to 7.7 and 7.8.

Question no	Question	Answer options	Guidance / definitions
7.9	Did the patient require help with personal activities of daily living (ADL)?	Yes; No	*Unavailable if 7.1 = "Died in hospital" OR "Was discharged to a care home" OR "Was transferred to another inpatient care team" OR "Was transferred to another inpatient care team, not participating on SSNAP"* *Unavailable if 7.1.4 = 'Care home'* Personal activities of daily living (PADL) refer to a range of basic activities such as washing, dressing, bathing, going to the toilet, eating and drinking. Help means physical assistance. This is not applicable if the person is able to be independent in PADL with the use of aids and adaptations.
7.9.1	What support did they receive?	Paid carers; Informal carers; Paid and informal carers; Paid care services unavailable; Patient refused	*Unavailable if 7.9 = No* Paid carers can include self-funded or via local authority/social services or reablement. Informal care may be provided by family, friends or voluntary organisations
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	*Unavailable if 7.9 = No* Unavailable if 7.9.1 = 'Informal carers' OR 'Paid services unavailable' OR ' Patient refused' Please include all formal care visits provided by social services, via external reablement services, self-funded or care visits provided by community rehabilitation teams.
7.9.4	How many carers?	One carer; Two carers ; Not known	*Unavailable if 7.9 = No* Unavailable if 7.9.1 = 'Informal carers' OR 'Paid services unavailable' OR ' Patient refused' If number of carers varies per visit, please indicate the higher value.

Question no	Question	Answer options	Guidance / definitions
7.10	Is there documented evidence that the patient is in atrial fibrillation on discharge?	Yes; No	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* This question does not need to be answered for patients who died in hospital. Answer 'Yes' if the patient is in persistent, permanent or paroxysmal atrial fibrillation.
7.10.1	If yes, was the patient taking anticoagulation (non-antiplatelet agent) on discharge or discharged with a plan to start anticoagulation within the next month?	Yes; No; No but	*Available if 7.10 = Yes* Anti-coagulation refers to treatment with an anti-coagulant such as warfarin or phenindione, and not an antiplatelet such as aspirin or clopidogrel. A plan for anti-coagulation may consist of direction to the GP to review the patient for warfarin. This should be clear in the discharge letter or summary.
7.11	Is there documented evidence of joint care planning between health and social care for post discharge management?	Yes; No; Not applicable	Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team" Not applicable is for patients who are not resident in the UK, who refuse a health and/or social care assessment or intervention, or who only have a health *or* a social care need (not both) or no need for either. This no longer requires provision of patient held copy of joint health and social care plan on discharge (although this continues to be good practice).
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	*Unavailable if 7.1 = "Died in hospital" OR "Was transferred to another inpatient care team"* This can include a stroke key worker.

Question no	Question	Answer options	Guidance / definitions
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 "No, patient refused consent" 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". 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'
7.15	Please state if this patient gave consent for their information to be included in research using SSNAP data?	Yes, patient gave consent; No, patient refused consent; Patient not asked	Please record if the patient has given or refused consent specifically for the use of their data in research. It is not a requirement to ask this question however if the patient has been asked or has given or refused consent for research without being asked then this should be recorded here. If the patient refuses consent, none of their data will be used for research. This question refers specifically to the use of data in research and not for audit purposes. If the patient has given or refused consent for the use of their patient identifiable data in SSNAP, this should be recorded in the appropriate question in the dataset. If the patient was not asked for consent, please record "patient not asked". If patient medically unwell and cannot be asked, indicate "patient not asked".

Appendix:

Guidance for recording days and minutes of therapy and care:

You are asked to record days and minutes of therapy or care delivered by any staff member that addressed the needs or functions identified by each category heading.

Days are 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. This is not the number of sessions, but calendar days.

Please attribute minutes to the category that best describes the main focus of that therapeutic session, or part of a session. Where there is more than one focus to a single session then minutes would be apportioned for each part and added up under each category appropriately. Please do not count the same minutes under more than one category, and do not double-count within the same category

For example:

- If a therapist works on two different categories of rehabilitation during a 60 minute session, record the number of minutes for each category (e.g. 30 minutes for motor function, 30 minutes for communication). Please refer to patient notes to accurately determine the split per each.
- If two therapists (of different disciplines or the same discipline) treat a patient at the same time, focused on the same category of rehabilitation, record the number of minutes of therapy the patient received e.g. 2 therapists providing rehabilitation for motor function to a patient for 45 minutes counts as 45 minutes of motor function therapy (not 90 minutes), therefore recording how many minutes the patient received rather than recording the time therapy staff spent providing the session.
- Where a 60 minute session has required two members of staff and one is qualified and one is an assistant and they are both providing the same category of rehabilitation, assume the session has been led by the qualified therapist, record 60 minutes of therapy received by the patient as qualified and do not record any minutes as assistant provided. (i.e., do not split minutes across staff groups), therefore recording how many minutes the patient received rather than recording the time therapy staff spent providing the session.

The recorded treatment minutes can be provided by any clinician, assistant, support worker or student under supervision, with stroke specific knowledge and skills pertinent to the rehabilitation being undertaken, the underlying impairment and treatment modality. The input provided should form part of delivery of a documented evidence-based therapy treatment plan; be informed by assessment and patient specific goals; be progressive in nature, with capability for concurrent (re-)assessment and grading where appropriate. Delivery of routine care, such as providing personal care, toileting or transfers should not be included as rehabilitation.

This can include team members employed by different organisations (such as charities or local authority colleagues) who work within the service; have regular access and discussions with clinicians (may attend MDTs); and are aware of treatment plans and goals.

Team members external to the registered team on SSNAP who work within/alongside the stroke team with honorary contracts, SLA's, MOU's.
AND where robust and reliable data can be collected regarding patient contact
AND where staff providing this input are regularly updated regarding stroke knowledge and skills.

Therapy:

- 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 around issues related to a specific patient (i.e. not general training)
- setting up, supporting and advancing self-directed exercise programmes (independent practice not included)
- Semi supervised practice (such as in open gyms with oversight and interaction with practitioner)
- App-based therapy (face-to-face or synchronous)

Care:

- assessment (of patients and carers)
- advice and support (with patients and carers)
- assessment, trials and evaluation of home adaptation
- training of care staff

In this definition therapy **does not** include

- documentation
- environmental visits
- multidisciplinary team meetings
- case conferences/case reviews (where patient is not present)
- development of resources (where patient is not present)
- Independent practice
- App-based therapy (asynchronous)

To help decide which therapeutic interventions should come under which category, examples have been provided under the category headings below. These categories reflect a patient focused approach and are designed to help record the dose and frequency of therapy and care delivery in a more meaningful way. They have been informed by recommendations in the National Clinical Guideline for Stroke 2023.

<table>
<tr><td colspan="2">It is not the intention to capture all the activity of members of your team. This approach is designed to focus on functions for which there is evidence that increased dose and frequency of therapy is more beneficial for patients. These functions reflect the types of rehabilitation and care that services are required to deliver as recommended in the National Clinical Guideline for Stroke 2023.

Only record time spent in treatment or rehabilitation under the supervision of a healthcare professional, either one-to-one or in a group session. Do <u>not</u> include independent practice by the patient on their own or without a healthcare professional present.</td></tr>
<tr><td>Motor function</td><td>Only included where there is professional direction in person. This includes semi-supervised sessions e.g. open gym but does <u>not</u> include independent practice outside of these sessions.

Please note ‘motor function’ does not cover all aspects of motor-based rehabilitation, but captures exercise, strength and activity related to sitting, standing, upper limb, gait and balance.

Includes:
Repetitive task practice
Functional tasks with a therapeutic approach to improve motor function i.e. improve standing tolerance, dynamic balance, trunk control (midline), reach to grasp in a task
Mobility practice, real world walking
Progressive balance training
Treadmill training
Strength training
Trunk/Sitting balance work
Sensory retraining
Functional Electrical Stimulation
Mirror therapy
Constrained Induced movement therapy
Mental imagery
Spasticity management
Exercise targeted at motor recovery including sensorimotor, strength or coordination
Home visits from an inpatient setting where primary focus was physical abilities
Further assessment specifically aimed at motor function
Outcome measures specifically aimed at motor function (i.e. not holistic outcome measures required by SSNAP e.g., Barthel which are captured in ‘other’)</td></tr>
</table>

	Does not include independent practice; wandering between therapy sessions or as part of normal daily living (such as to and from the toilet); sitting out; normal daily eating and drinking; splint wearing. Exercise for cardiovascular fitness should not be included (please include in 'other'). This does not include initial assessment

Psychological function	Includes:
	• Cognitive assessment
	• Perceptual assessment (including for visual neglect)
	• Mood assessment
	• Level 1,2 or 3 psychological support including;
	  • Low level interventions such as supportive conversations, goal setting, relaxation methods such as tai chi
	  • Psychoeducation
	  • Psychological interventions e.g. Motivational interview, Cognitive Behavioural Therapy, Acceptance + Commitment Therapy, anxiety management.
	• Impairment based training e.g. attention work, memory training, insight work, Inattention training
	• Fatigue management including patient education
	• Functional tasks focussed on assessment of/improvement of functional impact of cognitive/perceptual impairments- i.e. improvement in sequencing, planning, object use, problem solving, self-monitoring and self-awareness, risk management, apraxia, agnosia, neglect. This may include assessment of functional tasks such as multiple errands, road crossing, money management, driving
	• Functional tasks focussed on mood e.g. meaningful activity, anxiety management, self-care
	• Capacity assessment (where the predominant reason for assessing capacity is due to cognitive or mood issues)
	• Training the patient in the use of phones, emails etc for the purpose of communicating with others where the approach is related to cognitive deficits i.e. learning, memory, attention, navigation of device
	• Home visits from an inpatient setting where primary focus was cognitive abilities
	
	Does <u>not</u> include report writing or activity pertaining to work which is not patient facing such as MDT formulation or education of staff. Does not include obtaining social history, initial assessments or discharge discussions. Note therapy pertaining to cognitive communication disorders sits within communication/swallowing function)

Communication/swallowing	Includes:
	• Assessment, intervention, education and support provided for
	  • Aphasia – including interventions targeting impairment, participation and activity.
	  • Dysphagia – including behavioural exercises, swallow stimulation, neurostimulation, supervised oral trials.

	• Dysarthria – including motor exercises for facial weakness or dysarthria, communication and intelligibility techniques. • Apraxia of speech – including motor training exercises, communication strategies and techniques. • Cognitive communication disorders • Reading, writing, speech, numerical work • Assessment for and training with communication aids and assistive devices • Communication partner training • Communication stimulation – creating opportunity for supervised communication practice 1:1 or in groups. • Facilitating communication in important discussions/decisions- including capacity assessment for those with significant aphasia (i.e. where aphasia is the primary issue impacting demonstration of capacity). Where discussions/capacity assessment is carried out by two professionals, enter under psychological only, so not to double count minutes. Does not include report writing or activity pertaining to work which is not patient facing, such as creation of individualised resources. Does not include initial assessment.
Other	Includes: • Initial assessment (comprehensive/holistic assessment carried out by stroke specialist professional) • Goal setting meetings • Visual assessment • Ocular motor and visual field interventions. (Note interventions associated with visual perception and visual neglect are included in psychological domain) • Social History Gathering – with patient (not by proxy) • Discharge planning discussions with patient (not by proxy) • Wheelchair assessment • Wheelchair training • Collection of SSNAP required outcome measures (EQ5DL, Barthel and MRS) • Medication assessment – self assessment for medication administration • Discussion with patient re medication purpose, compliance, rationalisation • Chest physiotherapy • Healthy living and lifestyle management • Exercise for cardiovascular fitness • Other patient facing therapeutic activity that is not covered by the categories above but that fit the criteria under "**Guidance for recording days and minutes of therapy and care"** within the appendix.

	Does not include report writing or activity pertaining to work which is not patient facing, such as discussions with family, meetings regarding care allocation, equipment ordering, administrative emails/telephone calls. Domain specific outcome measures (not required by SSNAP) should be entered under the most relevant therapy domain (i.e. balance measures recorded as minutes under motor function).