

TIA/Minor Stroke Dataset Help Notes

Version Control

Version	Date	Changes
1.1.1	12/12/2012	First version
2.1.1	07/12/2020	Updated to KCL logo
3.1.1	26/03/2026	Updated help notes with additional questions

On behalf of the Intercollegiate Stroke Working Party

SSNAP Helpdesk

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Question no	Question	Answer options	Guidance / definitions
Section 1 - Demographics			
	Hospital	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.

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			Age associated with severity of stroke is an important predictive factor for outcome, both in terms of mortality and resulting dependency.
1.6	Gender	Male; Female; indeterminate/not specified	To investigate any differences between men and women in prevalence or outcomes.
1.7	Postcode of usual address		<p>Please enter the full postcode of the patient's normal place of residence.</p> <p>The postcode is used for data linkage purposes, particularly where the NHS number is not known or potentially incorrect. The postcode can also be used to investigate numbers and severity of stroke in different parts of the country and whether there are any geographical inequalities in service provision, quality of care or patient outcomes.</p>

Question no	Question	Answer options	Guidance / definitions
1.8	Ethnicity	A British B Irish C Any other White background D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background H Indian J Pakistani K Bangladeshi L Any other Asian background M Caribbean N African P Any other Black background R Chinese S Any other ethnic group Z Not stated 99 Not known	The ethnicity of a person, as specified by the person. Z= The person had been asked and had declined either because of refusal or genuine inability to choose. 99 'Not known' should be used where the patient had not been asked or the patient was not in a condition to be asked, e.g. unconscious. Ethnicity can be used to investigate numbers and severity of stroke for different ethnic groups and whether there are any inequalities in service provision, quality of care or patient outcomes.
Section 2 – Clinical information			
2.1	The patient was managed in:	Emergency department Acute Medical Unit Same-day Emergency Care Ambulatory Care unit Outpatient Clinic	The principal location where the patient received the majority of their care.

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		Other location Telephone or video consultation only	
2.2	Date/time of onset of symptoms	dd/mm/yyyy hh:mm	The date (dd/mm/yyyy) and time (hh:mm) when the patient (or witness) was first aware of focal neurological symptoms.
2.3	Date/time first seen by healthcare professional	dd/mm/yyyy hh:mm	When the patient first met a healthcare professional after the onset of their symptoms. For patients seen more than once in primary care or Emergency Department with the same episode, record the first contact, even if the diagnosis of suspected TIA was not considered until a second or subsequent contact.
2.4	Date/time referral received	dd/mm/yyyy hh:mm	The date and time when the service provider received the referral from the first medical contact (e.g. GP, Emergency Department, Walk-in Centre, Ambulance service). The date and time recorded should be that of the arrival of the referral with the service provider (e.g. the time of receipt of a fax or e-mail) rather than the date when the referral first came to attention. E.g. a referral sent & received from an out of hour's service on a Saturday morning is recorded from receipt, rather than the time the referral was picked up on Monday morning.
2.5	Date/time first clinical assessment by stroke-skilled clinician	dd/mm/yyyy hh:mm	
2.6	The final diagnosis was	TIA Ischaemic stroke Intracerebral haemorrhage Ocular stroke Stroke mimic/other diagnosis	

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2.6.1	If stroke mimic/other, please specify	Migraine Peripheral vestibular syndrome Functional neurological disorder/non-organic symptoms Seizure Subdural haematoma Intracranial tumour – benign Intracranial tumour – malignant Bell’s palsy Syncope Delirium Fall Decompensation of old stroke impairments Peripheral nerve/neuropathy/neuropraxia Other	2.6.1 is available if 2.6 is stroke mimic/other diagnosis

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2.7	Vascular prevention treatments prescribed at initial assessment		
2.7.1	Single antiplatelet therapy	Yes/No	
2.7.2	Dual antiplatelet therapy	Yes/No	
2.7.3	Anticoagulant therapy	Yes/No	
2.7.4	Lipid-lowering therapy	Yes/No	
2.7.5	Blood pressure-lowering therapy	Yes/No	
2.7.6	Lifestyle modification	Yes/No	
2.8	Did the patient have an assessment by a stroke-skilled therapist at their initial visit?	Yes/No/No disability-not indicated	
2.8.1	If yes, did this include vision screening?	Yes/No	2.8.1 is available if 2.8 is yes

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2.8.2	If yes, did this include cognitive screening?	Yes/No	2.8.2 is available if 2.8 is yes
2.8.3	If no, was an onward referral for assessment made to a stroke skilled community service/outpatient service	Yes/No	2.8.3 is available if 2.8 is no
2.9	Did the patient have any of the following co-morbidities prior to this episode?		Record a 'Yes' only if these conditions were known before specialist assessment (usually listed in the 'Past Medical History' at assessment or in the referral), and not if any were newly diagnosed on this occasion. Where the presence or absence of these conditions is not recorded, do not check either box.
2.9.1	Cognitive Heart Failure	Yes/No	
2.9.2	Hypertension	Yes/No	
2.9.3	Atrial fibrillation	Yes/No	
2.9.4	Diabetes	Yes/No	
2.9.5	Stroke/TIA	Yes/No	
2.9.6	Dementia	Yes/No	

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2.10	Was the patient on antiplatelet medication prior to this episode?	Yes/No/No but	<p>Was the patient taking either antiplatelet medication (aspirin/dipyridamole/ clopidogrel) at the time of referral? For admitted patients, read ‘this episode’.</p> <p>Answer ‘no but’ if a contraindication to antiplatelet treatment is recorded.</p>
2.11	Was the patient on anticoagulant medication prior to this episode?	Yes/No/No but	<p>Was the patient taking either anticoagulant medication (warfarin/ dabigatran/rivaroxaban) at the time of referral? For admitted patients, read ‘this episode’.</p> <p>Answer ‘no but’ if a contraindication to anticoagulant treatment is recorded. The main contraindications to anticoagulant treatment (active gastrointestinal bleeding or cerebral haemorrhage) are also contraindications to antiplatelet treatment.</p>
2.12	Date/time of first brain imaging	dd/mm/yyyy hh:mm Not imaged Imaging not indicated	<p>Record ‘imaging not indicated’ for patients where none of the indications for brain imaging in TIA described in the National Stroke Strategy apply (typically patients with a single uncomplicated episode of sudden focal neurological symptoms which have entirely resolved within 24 hours where there is no uncertainty regarding the vascular territory involved, or those with amaurosis fugax/transient monocular blindness).</p> <p>Record ‘Not imaged’ if one of those indications does apply, but CT or MRI was not performed.</p>

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2.12.1	What was the initial brain imaging modality	NCCT CT Angiogram MRI MR Angiogram	2.12.1 is unavailable if 2.12 is Not imaged or Imaging not indicated
2.13	Did the patient have severe symptomatic ipsilateral carotid stenosis?	Yes No Carotids not imaged Carotid imaging not indicated	<p>Record 'No' if a diagnostic test was performed (carotid duplex ultrasound or MR or CT angiography), but a carotid stenosis was either not found, or any stenosis found was described as <50% diameter stenosis by the NASCET method.</p> <p>Record 'imaging not indicated' for patients not considered suitable for carotid endarterectomy on the basis of co-morbidity or operative risk, or because the TIA was in the posterior circulation, or because the patient refused further investigation.</p> <p>Where none of those exclusions apply, but a diagnostic carotid test was not performed (carotid duplex ultrasound or MR or CT angiography), record 'Not imaged'.</p>
2.13.1	Date/time of carotid intervention	dd/mm/yyyy hh:mm Or carotid intervention not indicated	2.13.1 is available if 2.13 is Yes

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2.14	<p>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</p>	<p>Yes, patient gave consent</p> <p>No, patient refused consent</p> <p>Patient was not asked</p>	