SSNAP | Sentinel Stroke National Audit Programme

KING'S College LONDON

TIA 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**

On behalf of the Intercollegiate Stroke Working Party

SSNAP helpdesk
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Question no	Question	Answer options	Guidance / definitions
Demographic section – Section 1			
	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. Age associated with severity of stroke is an important predictive factor for outcome, both in terms of mortality and resulting dependency.

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1.6	**Gender**	Male; Female	To investigate any differences between men and women in prevalence or outcomes.
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. 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.
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.

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1.9	**What was the diagnosis?** **This question does not appear on the webtool in the TIA and Other sections as it is inherently known by choosing TIA or Other.**	Stroke; TIA; Other	If TIA or Other is selected, please go straight to the TIA/Other section (non-mandatory). It is optional to enter TIA patients (inpatients and outpatients) and patients who elicit a response from the stroke team (stroke mimics). 'Suspected TIA' is defined by the referrer – any patient referred to hospital as suspected TIA should be recorded here, rather than only those patients with a final diagnosis of TIA after specialist evaluation or diagnostics. Multiple overlapping sources should be used to verify complete case ascertainment, including: 1. Referrals made through conventional channels, such as those made to a Neurovascular clinic; 2. Referrals made from emergency departments, medical assessment units, ambulatory care facilities, ophthalmology clinics and existing hospital in-patients; 3. Cases coded on discharge as TIA (or suspected/possible/probable TIA).
Section 2			
2.1	**The patient was an:**	Inpatient/outpatient	The principal location where the patient received the majority of their care.
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.

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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 seen in neurovascular clinic**	dd/mm/yyyy hh:mm or Not seen in neurovascular clinic	The date and time when the patient first met a 'stroke specialist' with skills and experience sufficient to make a diagnosis and implement a management plan. If the patient declines the first out-patient appointment offered, record here the date/time of that appointment, rather than the later one the patient chooses. For patients admitted as an emergency with suspected TIA, record the 'date/time of referral' as when the patient was first seen by emergency services (ambulance/out of hours/walk-in centre), the 'date/time referral received' from when the patient arrived at hospital, and the 'date/time first seen' as the time when the patient first met a 'stroke specialist' (as defined) rather than Emergency Department or Medical Assessment Unit staff. In these instances, and in cases where the patient was referred to another type of clinic (e.g. general neurology or medicine), check the 'Not seen in neurovascular clinic' box.
2.6	**ABCD2 score**	0-7	Enter the ABCD2 score based on the assessment of the *referrer,* not the subsequent assessment by the stroke specialist unless it is higher than score from referrer. Also classify the following referrals as high-risk:

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			Patients with recurrent symptoms within one week of referral. Patients on warfarin or in atrial fibrillation at the time of referral. For these patients enter the value '7'.
2.7	**Date investigations/treatment completed**	dd/mm/yyyy	The date when the relevant investigations were reviewed by the stroke specialist who requested them 'Relevant investigations' include: Where indicated, brain imaging (record the date/time when the result was reviewed, rather than when the investigation was performed or reported); Where indicated, carotid duplex imaging (as above); ECG (as above). Typically, other investigations such as 24-hour tape and echocardiogram do not contribute to this indicator.
2.7	**Time investigations/treatment completed**	hh:mm	
2.8	**Date antiplatelet given**	dd/mm/yyyy Antiplatelet not given Antiplatelet contraindicated	The date when the patient is recorded as taking their first dose of antiplatelet medication. Where this is not recorded, but the issuing of a prescription is recorded, or where the instruction is given in a clinic letter or discharge summary, check the 'Antiplatelet not given' box. If the patient is already on antiplatelet treatment (aspirin, dipyridamole or clopidogrel) when first seen, duplicate here the date/time first seen from Questions 1.4.1 & 1.4.2.

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			Contraindications to antiplatelet treatment include current active gastrointestinal bleeding, and cerebral haemorrhage. Patients with a recorded allergy to aspirin are not also allergic to dipyridamole or clopidogrel.
2.8	**Time antiplatelet given**	hh:mm	
Section 3			
3.1	**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.
3.1.1	**Congestive heart failure**	Yes/No	
3.1.2	**Hypertension**	Yes/No	

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3.1.3	**Atrial fibrillation**	Yes/No	
3.1.4	**Diabetes**	Yes/No	
3.1.5	**Stroke/TIA**	Yes/No	
3.1.6	**Was the patient on antiplatelet medication prior to admission?**	Yes/No/No but	If 2.1.3 (atrial fibrillation) is Yes: Was the patient taking either antiplatelet medication (aspirin/dipyridamole/ clopidogrel) at the time of referral? For admitted patients, read 'this episode'. Answer 'no but' if a contraindication to antiplatelet treatment is recorded.
3.1.7	**Was the patient on anticoagulant medication prior to admission?**	Yes/No/No but	If 2.1.3 (atrial fibrillation) is Yes: Was the patient taking either anticoagulant medication (warfarin/ dabigatran/rivaroxaban) at the time of referral? For admitted patients, read 'this episode'. 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.
3.2	**Which health professional first saw the patient?**	GP/A&E/Other	'GP' refers to any professional in a primary care setting e.g. practice nurse or nurse practitioner.
3.2.1	**If other, please specify**	Free text (30 character limit)	
3.3	**Date of first brain imaging**	dd/mm/yyyy /Not imaged / Imaging not indicated	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

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			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). Record 'Not imaged' if one of those indications does apply, but CT or MRI was not performed.
3.3	**Time of first brain imaging**	hh:mm	
3.3.1	**What was the initial brain imaging modality?**	CT/MRI	
3.4	**Did the patient have significant and treatable carotid stenosis?**	Yes/No/Not imaged/Imaging not indicated	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. 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. 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'.
3.5	**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**	Yes, patient gave consent / No, patient refused consent / Patient was not asked	

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	if the patient gave consent for their identifiable information to be included in SSNAP?		