Supplementary Helpnotes for Early Supported Discharge & Community Rehab Teams

Version	Date	Changes	To be reviewed
1.1.1	30.03.2015	Supplementary Helpnotes for community providers following pilot versions	30.03.2016
2.1.1	07.12.2020	Updated to KCL logo	
3.1.1	01.07.2021	Questions 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	

These supplementary helpnotes have been produced specifically for stroke care providers treating patients in the community. Only the sections of the SSNAP dataset (sections 4, 7, and 8), and accompanying guidance text relevant to community teams on SSNAP are provided in this document. In contrast, the SSNAP Core Dataset Helpnotes also available on the SSNAP webtool include every section of the dataset and not only those pertaining to community providers. There is also additional help text included in these helpnotes which provide further guidance to community users on the most appropriate way of capturing every stroke patient on SSNAP. This will help ensure that consistent, high quality data are being submitted to SSNAP by all teams working in a community setting.

For more information on the SSNAP Clinical Audit, including the background, aims, and timeframes of the audit, please refer to the SSNAP Core Dataset helpnotes in the Support section of the webtool, or visit the SSNAP website, www.strokeaudit.org.

These helpnotes have been created in collaboration with the East Midlands Academic Health Science Network and East Midlands Strategic Clinical Network.

On behalf of the Intercollegiate Stroke Working Party
SSNAP helpdesk
Mon-Fri 09:00-17:00
Tel: 0116 464 9901
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Number	Question	Answer options	Guidance/definitions
	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 team 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)	This information is already populated and cannot be altered.
1.2	NHS number	Either 10 character NHS number or 'No NHS number'	This information is already populated and cannot be altered.
1.3	Surname	Free text (30 character limit)	This information is already populated and cannot be altered.
1.4	Forename	Free text (30 character limit)	This information is already populated and cannot be altered.
1.5	Date of birth	Dd/mm/yyyy	This information is already populated and cannot be altered. 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.
1.6	Gender	Male/female	This information is already populated and cannot be altered. To investigate any differences between men and women in prevalence or outcomes.
1.7	Postcode of usual address	First box: 2-4 alphanumeric Second box: 3 alphanumeric The full postcode of the patient's normal place of residence.	This information is already populated and cannot be altered.

Number	Question	Answer options	Guidance/definitions
4.1	Date/time patient arrived at this hospital/team	Dd/mm/yyyy hh:mm	For community providers this is the date of the first face to face assessment. This does not include clinical phone calls. **All of section 4 must be answered by each team.** For non-inpatient teams (ESD and community rehab) this is the date/time the team first had face to face contact with the patient.
4.2	What was the first ward the patient was admitted to at this hospital?	MAU/AAU/CDU, Stroke Unit, ITU/CCU/HDU, Other	This question is greyed out and populated from the core dataset.
4.3	Date/time patient arrived on stroke unit at this hospital	Dd/mm/yyyy hh:mm or did not stay on stroke unit	This question is greyed out and populated from the core dataset.
4.4	Was the patient considered to require this therapy at any point in this admission? 1. Physiotherapy 2. Occupational therapy 3. Speech & language therapy 4. Psychology	Yes/No (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	This collects whether a patient was considered by the team involved to require Occupational therapy, Physiotherapy, Speech and Language therapy and Psychology at any point during their total stay under the care of your team. If a patient is assessed and does not need any further therapy then the patient was not considered to require therapy at any point in this admission. Answer 'No'. If a patient is assessed and requires further therapy, answer 'Yes'. If Yes is selected, the assessment time should be included (in minutes) as part of the total therapy time. (Assessment + Therapy sessions time = Total amount of therapy received). NB: For Psychology this refers to the delivery of care by psychologists or psychologist assistant. Only psychological support delivered by a psychologist or psychologist assistant can be recorded.

Number	Question	Answer options	Guidance/definitions
			If patients have received psychological support from other members of the team e.g. mental health nurse/OT/nurse this question should be recorded as no for Psychology.
4.4.1	If yes, at what date was this patient no longer considered to require this therapy? 1. Physiotherapy 2. Occupational therapy 3. Speech & language therapy 4. Psychology	Dd/mm/yyyy (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	This should be the date that the patient was no longer considered to have a deficit for each of the 4 therapies. E.g., A date can be entered for when the patient no longer required speech and language therapy which can be before the date they no longer required other therapies. This is NOT when patients are unable to tolerate 45 minutes of therapy, but when a patient would no longer benefit from therapy
4.5	On how many days did the patient receive this therapy across their total stay in this hospital/team?	Integer (For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	This is the total number of days on which the patient received each type of therapy from the day they arrived at the team to the day they left the team. The therapy may be provided by qualified or non-registered therapy assistants, including rehabilitation assistants, under supervision. For speech and language therapy it includes dysphagia and communication therapy. For psychologists it includes activities including assessment and treatment of mood, higher cognitive function and non-cognitive behavioural problems by psychologists or assistant psychologist. Therapy includes: • 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 • Speech and Language Therapy refers to communication therapy and swallowing therapy • Setting up, supporting and advancing self-directed exercise programmes

Number	Question	Answer options	Guidance/definitions
			In this definition therapy does not include • time for the therapist to travel to and from the patient • documentation • environmental visits • multidisciplinary team meetings • case conferences • case reviews
4.6	How many minutes of this therapy did the patient receive during their stay in this hospital/team?	(For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	This must be answered in minutes, which must be a whole number. *Cannot be more than 300 minutes per day (300 x number of days)* *Available if 4.5.1 > 0* This should include both face-to-face and video/teletherapy The therapy may be provided by qualified or non-registered therapy assistants, including rehabilitation assistants, under supervision. For speech and language therapy it includes dysphagia and communication therapy. For psychologists it includes activities including assessment and treatment of mood, higher cognitive function and non-cognitive behavioural problems by psychologists or assistant psychologist. - The stay refers to the team answering the question. The unit of measurement is minutes. The number of minutes must be a whole number - If two therapists of the same profession treat a patient at the same time, record the number of therapy minutes provided as the duration of the session e.g. 2 physiotherapists treating a patient for 45 minutes counts as 45 minutes of physiotherapy

Number	Question	Answer options	Guidance/definitions
			- If two therapists of different professions treat a patient at the same time, record the total number of minutes for each therapy e.g. a physiotherapist and occupational therapist treating a patient for 45 minutes counts as 45 minutes of physiotherapy and 45 minutes of occupational therapy - If one therapy assistant works on two different therapies during a 45 minutes session, record 45 minutes for only one profession or the times can be split (e.g. 25 minutes for one, 20 minutes for the other). See FAQs (ssnap.zendesk.com) for more information.
4.6.1	How many of the total therapy minutes were provided by a rehabilitation assistant?	(For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	*Available if 4.5.1 > 0* This is the number of the total therapy minutes recorded in 4.6 that were provided specifically by a non-registered rehabilitation or therapy assistant. 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) If one therapy assistant works on two different therapies during a 45 minutes session, record 45 minutes for only one profession or the times can be split (e.g. 25 minutes for one, 20 minutes for the other). Please refer to patient notes to accurately determine the split per each therapy.
4.6.2	How many of the total therapy minutes were delivered by video/teletherapy? 1. Physiotherapy 2. Occupational therapy 3. Speech & language therapy 4. Psychology	(For each of the following: Physiotherapy, Occupational Therapy, Speech and Language Therapy, Psychology)	*Only available to non-inpatient teams* *Available if 4.5.1 > 0* This is the number of the total therapy minutes recorded in 4.6 that were provided specifically via video/teletherapy.

Number	Question	Answer options	Guidance/definitions
			This is contact with the patient that is therapeutic and focused on their rehabilitation goals. Please do not include activities relating to administration (e.g. booking appointments).
4.7	Date rehabilitation goals agreed	Dd/mm/yyyy 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 were agreed, what was the reason?	PR - Patient refused OR - Organisational reasons MU - Patient medically unwell for entire admission NI - Patient has no impairments NRP - Patient considered to have no rehabilitation potential NK - Not known	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 to be unable to tolerate an assessment by clinical staff. 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).
4.8	Was the patient considered to require nursing care at any point whilst under the care of this team?	Yes, No	This item should only record nursing from within your service. This relates to input provided by registered nurses and does not include care visits. This item collects whether a patient was considered by the team involved to require nursing care at any point during their total stay under the care of your team.
4.8.1	If yes, at what date was the patient no longer considered to require this care?	DD/MM/YYYY	This should be the date that the patient was no longer considered to have a requirement for nursing care from your team. This item should only record nursing from within your service.
4.8.2	On how many days did the patient receive nursing care		This item should only record nursing from within your service.

Number	Question	Answer options	Guidance/definitions
	across their total stay in this team?		This is the total number of days on which the patient received nursing care from the day their care became the responsibility of this team to their discharge date from that team. It is collected separately for each team.
4.8.3	On how many days did the patient receive nursing care across their total stay in this team?		- The stay refers to the team answering the question. The unit of measurement is minutes. The number of minutes must be a whole number - If two nurses treat a patient at the same time, record the number of minutes provided as the duration of the session e.g. 2 nurses treating a patient for 45 minutes counts as 45 minutes of nursing care This item should only record nursing from within your service.
4.9	Date patient screened for mood using a validated tool	DDMMYY or Not Screened	Patients should have a reassessment in the non-acute stage. 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.
4.9.1	If not screened, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission	Patient medically unwell should be answered if the patient was 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.
4.10	Date patient screened for cognition using a simple standardised measure?	DDMMYY or Not Screened	Patients should have a reassessment in the non-acute stage. Cognition measure is one which has been approved for use within the trust/ health board such as MOCA/OCS.

Number	Question	Answer options	Guidance/definitions
			A standardised measure is one with evidenced validity and efficacy for use in stroke. Locally developed screening tools are not applicable.
4.10.1	If not screened, what was the reason?	NK = Not known OR = Organisational Reasons PR = Patient Refused MU = Patient medically unwell for entire admission	Patient medically unwell should be answered if the patient was 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.
7.1	The patient:	Died, Was discharged to a care home, Was discharged home, Was discharged to somewhere else, Was transferred to another inpatient care team, Was transferred to an ESD/CST, Was transferred to another inpatient care team not participating in SSNAP, Was transferred to an ESD/CST team not participating in SSNAP	'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 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). '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.

Number	Question	Answer options	Guidance/definitions
			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. Only one option can be selected in this question. The option selected influences whether further questions become available or remain greyed out.
7.1.1	If the patient died, what was the date of death?	Dd/mm/yyyy	This question is greyed out unless 'Died' is selected in 7.1
7.1.2	Did the patient die in a stroke unit?	Yes/No	This question is greyed out.
7.1.3	Which hospital/team was the patient transferred to?	Enter hospital/team code	*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 (service reconfiguration etc). OR The team has been set up recently and is not currently participating (eg newly set up post acute team). 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. If a team is unlikely to submit data soon, especially close to deadlines, it is appropriate to enter 'discharged somewhere else' in 7.1, then lock to discharge. If the record is already locked, please send through a request to the helpdesk, stating the reason for the unlock.

Number	Question	Answer options	Guidance/definitions
7.2	Date/time of discharge from stroke unit	Dd/mm/yyyy hh:mm	This question is greyed out.
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*
7.3.1	Date patient considered by multidisciplinary team to no longer require inpatient care	Dd/mm/yyyy	This question is greyed out.
7.4	Modified Rankin Scale score at discharge/transfer	0-6	Defaults to 6 if 7.1 is patient died. 0: No symptoms at all 1: No significant disability despite symptoms; able to carry out all the 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
7.5	If discharged to a care home, was the patient:	Either "Previously a resident" OR "Not previously a resident"	'Not previously a resident' should be answered if the patient is going to a care home where they did not live before, or if they are going to the same care home but requiring a different level of care (e.g. they have moved from residential care to nursing care).
7.5.1	If not previously a resident, is the new arrangement:	Either "Temporary" OR "Permanent"	
7.6	If discharged home, is the patient:	Living alone; Not living alone; Not known	
7.7	Was the patient discharged with an Early Supported	Yes, stroke/neurology specific Yes, non-specialist	A stroke specific team is one that treats stroke/neurology patients solely.

Number	Question	Answer options	Guidance/definitions
	Discharge multidisciplinary team?	No	A generic/non-specialist team treats other patients in addition to stroke and neurology patients. Early supported discharge team refers to a multidisciplinary team which provides rehabilitation and support in a community setting with the aim of reducing the duration of hospital care for stroke patients. A stroke/neurology specific team is one which treats stroke/neurology patients solely. A non-specialist team treats other patients in addition to stroke and neurology patients.
7.8	Was the patient discharged with a multidisciplinary community rehabilitation team	Yes, stroke/neurology specific Yes, non-specialist No	A non-specialist team would typically be part of a generic intermediate rehabilitation team. These would typically be part of a community neuro-rehabilitation team. Non-specialist team would typically be part of a generic intermediate rehabilitation team.
7.9	Did the patient require help with activities of daily living (ADL)?	Yes, no	This question is greyed out.
7.9.1	If yes: What support did they receive?	Paid carers, Informal carers, Paid and informal carers, Paid care services unavailable, Patient refused,	This question is greyed out.

Number	Question	Answer options	Guidance/definitions
7.9.2	At point of discharge, how many visits per week were social services going to provide?	0-100 or 'not known'	This question is greyed out.
7.10	Is there documented evidence that the patient is in atrial fibrillation on discharge?	Yes, no	This question is greyed out
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	This question is greyed out
7.11	Is there documented evidence of joint care planning between health and social care for post discharge management?	Yes, no	This question is greyed out
7.12	Is there documentation of a named person for the patient and/or carer to contact after discharge?	Yes, no	This question is greyed out
7.13	Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?	• Yes • No • Not Known/not tested	*Confirmed = a positive test (of any kind) OR a negative test but diagnosed with COVID clinically and treated as such.* *This question refers to the patient's particular stay at this team. As the question is referring to confirmed diagnosis*
7.13.1	If Yes, was COVID-19	• Present on admission (i.e. the admission COVID test was positive)	*Unavailable if 7.13 is "No" OR "Not Known/not tested"*

Number	Question	Answer options	Guidance/definitions
		• Confirmed subsequently during the patient's stay • Confirmed after death	
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	For transferred patients, If Consent is set to "Yes, patient gave consent" OR "No, patient refused consent" in section 7 then that value will be copied to the new record and the section will have its status set to incomplete. 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". Patient identifiable information is not collected in Northern Ireland and so consent does not need to be sought. Northern Ireland teams should record "Not asked" for this question. 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'

Six Month Assessment Entry on SSNAP (post admission)

Number	Question	Answer options	Guidance/definitions
8.1	Did this patient have a follow-up assessment at 6 months post admission (plus or minus two months)?	Yes, No, No but, No, patient died within 6 months of admission	This forms part of the CCG Outcome Indicator Set for Domain 3 (Improving recovery from stroke); people who have had a stroke who receive a follow-up assessment between 4-8 months after initial admission. Where provision of six month reviews does not exist, the last team to treat the patient in the SSNAP record pathway should enter 'no' even though they would not know about patient status. SSNAP can correlate this with mortality data and adjust it for patient deaths. Though there are concerns over a lack of data when teams enter no, this information can still be used as a tool to highlight to commissioners where 6 month assessment services do not currently exist. It should not be seen as negative. ESD and CRT team should be registered as individual SSNAP teams. However, a 6 month assessment provider may be either registered as another individual team or form part of an ESD or CRT team on SSNAP. This decision can be made at local level. If a patient is still receiving therapy from CST at the time of their 6 month assessment, and this therapy is being recorded on SSNAP, the 6 month data can only be entered once the CST care has been completed and the record locked to discharge. 'No but' should be answered:

Number	Question	Answer options	Guidance/definitions
			• For patients who decline the assessment or who do not attend an appointment offered • Where an attempt is made to contact the patient, but they cannot be contacted as they are not registered with a GP or have moved overseas. For patients who have another stroke after being discharged from inpatient care and are readmitted into hospital See FAQs (ssnap.zendesk.com) for more information.
8.1.1	What was the date of the follow-up?	Dd/mm/yyyy	
8.1.2	How was the follow-up carried out?	In person; By telephone; Online; By post	
8.1.3	Which of the following professionals carried out the assessment?	GP; Stroke coordinator; Therapist; District/community nurse; Voluntary services employee; Secondary care clinician; Other	If a stroke nurse carried out the 6 month assessment you should select 'stroke coordinator' if he/she is a stroke nurse coordinator. If he/she is not a stroke nurse coordinator you should enter 'secondary care clinician' when the nurse is working in secondary care or 'district/community nurse' if he/she is working in the community.
8.1.4	If other, please specify	Free text	
8.1.5	Did the patient give consent for their identifiable information to be included in SSNAP?	Yes, patient gave consent; No, patient refused consent; Patient was not asked	This question is mandatory to be collected at the 6 month review and is a requirement for collecting patient identifiable information as part of our section 251 (NHS Act 2006) approval from the Ethics and Confidentiality Committee of the National Information Governance Board. If the patient refuses consent, all patient identifiable information will be wiped from the webtool. Every effort should be made to seek consent. However if this has not occurred we will still want the 6 month follow up information collected, this is why the dataset has the 'patient not asked' option.

Number	Question	Answer options	Guidance/definitions
			Where there is a comparatively high rate of 'patient not asked' option selected, SSNAP may seek assurance from the teams in question that there is an action plan in place to improve this.
8.2	Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?	Yes; No; No but	The term 'discharge' here is referring to discharge from an inpatient setting, not discharge from the entire stroke pathway. For patients that have followed an agreed mood pathway answer 'yes'. For patients who have not been seen by services before (e.g. those who had been seen out of area) the information should be available through the clinical systems. Otherwise the 6 month assessment provider teams will need to contact GPs.
8.2.1	Was the patient identified as needing support?	Yes; No	Some patients may not have been screened but may still require support. Unless the patient has been screened, this question is unavailable and this information cannot be recorded in SSNAP.
8.2.2	If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?	Yes; No; No but	This question is not limited to support provided by clinical psychologists and assistant psychologists. Teams who have provided support (e.g. from a mental health nurse) should tick 'yes'. A comment can also be added if needed for local recording purposes. Mood, behaviour or cognitive disturbance could include anxiety, emotionalism, depression, adjustment, denial and difficulty coping emotionally and psychologically, which impedes recovery, problems with orientation and memory and inappropriate behaviour. Psychological support can be provided by any professional or voluntary sector service specifically trained in psychological support.
8.3	Where is this patient living?	Home; Care home; Other	
8.3.1	If other, please specify	Free text	

Number	Question	Answer options	Guidance/definitions
8.4	What is the patient's modified Rankin Scale score?	0-6	The NHS outcomes framework stipulates that a modified Rankin Scale score is collected at six months – hence this needs to be carried out as part of the six month review. If this is not done, or when six month reviews are completed over the phone, and/ or the patient was previously unknown to the 6 month assessment team, previous information regarding their Modified Rankin Scale score and asking questions about their level of ability could be used to assist with scoring. However, scoring needs to be conducted at six months with the patient, meaning that a previous score should not be filled in. 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
8.5	Is the patient in persistent, permanent or paroxysmal atrial fibrillation?	Yes; No	Paroxysmal atrial fibrillation means episodes that last longer than 30 seconds but less than 7 days (often less than 48 hours) and are self-terminating and recurrent. Persistent atrial fibrillation means episodes lasting longer than 7 days (spontaneous termination of the arrhythmia is unlikely to occur after this time).

Number	Question	Answer options	Guidance/definitions
			Permanent atrial fibrillation (AF) means AF that fails to terminate using cardioversion, or is terminated but relapses within 24 hours, or longstanding AF (usually longer than 1 year) in which cardioversion has not been indicated or attempted (sometimes called accepted permanent AF).
8.6 (8.6.1-8.6.4)	Is the patient taking: Antiplatelet, Anticoagulant, Lipid Lowering, Antihypertensive?	Yes; No	
8.7 (8.7.1-8.7.3)	Since their initial stroke, has the patient had any of the following: stroke, myocardial infarction, other illness requiring hospitalisation?	Yes; No	
8.8	Employment status prior to stroke:	Working full-time; Working part-time; Retired; Studying or Training; Unemployed; Other	Prior to stroke = the time directly 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
8.8.1	Employment status currently:	Working full-time; Working part-time; Retired; Studying or Training; Unemployed; Other	Full-time is the equivalent of 35 hours a week Full-time and part-time work includes paid, unpaid and voluntary work This question aims to identify if the stroke survivor is back at work and in meaningful employment to the extent that they were before their stroke. If the survivor is employed but not yet ready to return to work, please record this as 'Other'.
8.9	EQ5D-5L score six months after stroke:		https://euroqol.org/publications/user-guides/ There should be only ONE response for each dimension Missing values are preferably coded as '9'

Number	Question	Answer options	Guidance/definitions
			Ambiguous values (e.g. two boxes are ticked for a single dimension) should be treated as missing values
a	Mobility	Value range: 1-5 OR 9	1: I have no problems in walking about 2: I have slight problems in walking about 3: I have moderate problems in walking about 4: I have severe problems in walking about 5: I am unable to walk about 9: Ambiguous or missing value
b	Self-Care	Value range: 1-5 OR 9	1: I have no problems washing or dressing myself 2: I have slight problems washing or dressing myself 3: I have moderate problems washing or dressing myself 4: I have severe problems washing or dressing myself 5: I am unable to wash or dress myself 9: Ambiguous or missing value
c	Usual activities (work, study, etc.)	Value range: 1-5 OR 9	1: I have no problems doing my usual activities 2: I have slight problems doing my usual activities 3: I have moderate problems doing my usual activities 4: I have severe problems doing my usual activities 5: I am unable to do my usual activities 9: Ambiguous or missing value
d	Pain/discomfort	Value range: 1-5 OR 9	1: I have no pain or discomfort 2: I have slight pain or discomfort 3: I have moderate pain or discomfort 4: I have severe pain or discomfort 5: I have extreme pain or discomfort 9: Ambiguous or missing value
e	Anxiety/Depression	Value range: 1-5 OR 9	1: I am not anxious or depressed 2: I am slightly anxious or depressed 3: I am moderately anxious or depressed 4: I am severely anxious or depressed 5: I am extremely anxious or depressed

Number	Question	Answer options	Guidance/definitions
			9: Ambiguous or missing value
f	How was your health today?	Value range: 1-100 OR 999	100 means the best health you can imagine 0 means the worst health you can imagine Missing values should be coded as 999 If there is a discrepancy between where the respondent has placed the X and the number he/she has written in the box, administrators should use the number in the box