SSNAP Dataset for Non-acute strokes

Version control

Version	Date	Changes
1.1.1	01/07/2021	Document created

Introduction to this dataset

ESD or CRT teams now have the ability to start SSNAP records in the community, such as those referred for therapy by a GP.

This is a limited function meant for data entry for patients who do not have a previous acute record and were not treated by an acute team on SSNAP. If the patient was treated by an acute team on SSNAP, the acute team should be starting the record. This function must only be used after the community team have ensured that patient does not exist on the regular webtool. Community teams must check with the previous teams to make sure there is not already a SSNAP record for the patient (that has not been transferred to the community team).

If a record is eventually transferred to a community team, you should contact SSNAP helpdesk (ssnap@kcl.ac.uk) to request that the record be deleted from the non-acute stroke section. The community team will then have to re-enter their data on the record that was transferred from the acute team.

When an ESD or CRT team start a record, they will have to answer Sections 4 and 7 as usual but are also required to input some patient information normally done by the acute team. **Some fields are unavailable to answer because they are not relevant for ESD/CRT teams. These questions are shown in grey boxes below.**

More information and contacts

For queries, please contact ssnap@kcl.ac.uk
SSNAP webtool: www.strokeaudit.org

To register a new team to participate in SSNAP please download, complete and return a new team registration form at the following link: https://www.strokeaudit.org/Resources/New-SSNAP-Users.aspx

Hospital / Team	Auto-completed on web tool
Patient Audit Number	Auto-completed on web tool

Section 1: Demographics

1.1. Hospital Number — Free text (30 character limit)

1.2. NHS Number — 10 character numeric — or — No NHS Number ○

1.3. Surname — Free text (30 character limit)

1.4. Forename — Free text (30 character limit)

1.5. Date of birth — dd / mm / yyyy

1.6. Gender — Male ○ Female ○

1.7. Postcode of usual address — 2-4 alphanumerics / 3 alphanumerics

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

1.9. What was the diagnosis? Stroke ○ TIA ○ Other ○ **Not acute stroke** ○ Auto-completed on web tool

1.10. Was the patient already an inpatient at the time of stroke? Yes ○ No ○

1.11. Date/time of onset/awareness of symptoms — dd / mm / yyyy / hh / mm

1.11.1. The date given is: Precise ○ Best estimate ○ Stroke during sleep ○

1.11.2. The time given is: Precise ○ Best estimate ○ Not known ○

1.12. Did the patient arrive by ambulance? Yes ○ No ○

If yes:

1.12.1. Ambulance trust — Default / Drop-down of all trusts

1.12.2. Computer Aided Despatch (CAD) / Incident Number — 10 characters — or Not known ○

1.13. Date/ time patient arrived at first hospital — dd / mm / yyyy / hh / mm

1.14. Which was the first ward the patient was admitted to at the first hospital?

MAU/ AAU/ CDU ○ Stroke Unit ○ ITU/CCU/HDU ○ Other ○

1.15. Date/time patient first arrived on a stroke unit — dd / mm / yyyy / hh / mm

Section 4: This admission

Although patients are not 'admitted' to a non-inpatient care setting for ESD and CRT teams this can be taken to mean the period whilst the patient was under the care of your service.

4.1. Date/ time patient arrived at this hospital/team Auto-completed on web tool based on 1.13

dd mm yyyy hh mm

4.2. Which was the first ward the patient was admitted to at this hospital?
MAU/ AAU/ CDU ○ Stroke Unit ○ ITU/CCU/HDU ○ Other ○

4.3. Date/time patient arrived on stroke unit at this hospital *(this question will be unavailable)*

dd mm yyyy hh mm

or Did not stay on stroke unit ○

	1. Physiotherapy	2. Occupational Therapy	3. Speech and language therapy	4. Psychology
4.4. Was the patient considered to require this therapy at any point in this admission?	Yes○ No○	Yes○ No○	Yes○ No○	Yes○ No○
4.4.1 If yes, at what date was the patient no longer considered to require this therapy?				
4.5. On how many days did the patient receive this therapy across their total stay in this hospital/team?				
4.6. How many minutes of this therapy in total did the patient receive during their stay in this hospital/team?				
4.6.1 How many of the total therapy minutes were provided by a rehabilitation assistant?				
4.6.2 How many of the total therapy minutes were delivered by video/teletherapy?				

4.7. Date rehabilitation goals agreed: or No goals ○

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

4.8. Was the patient considered to require nursing care at any point whilst under the care of this team?	Yes○ No○
4.8.1 If yes, at what date was the patient no longer considered to require this care?	
4.8.2. On how many days did the patient receive nursing care across their total stay in this team?	
4.8.3. How many minutes of nursing care in total did the patient receive during their stay in this team?	

4.9 Date patient screened for mood using a validated tool DD/MM/YYYY or Not Screened ○

4.9.1 If not screened, what was the reason? Enter relevant code

4.10 Date patient screened for cognition using a simple standardised measure?

DD/MM/YYYY or Not Screened ○

4.10.1 If not screened, what was the reason? Enter relevant code

Section 7: Discharge / Transfer

7.1. The patient:
Died ○
Was discharged to a care home ○
Was discharged home ○
Was discharged to somewhere else ○
Was transferred to another inpatient care team ○
Was transferred to an ESD / community team ○
Was transferred to another inpatient care team, not participating in SSNAP ○
Was transferred to an ESD/community team, not participating in SSNAP ○

7.1.1 If patient died, what was the date of death? *(this question will only be available if you answer "Died" in 7.1)*

dd mm yyyy

7.1.2 Did the patient die in a stroke unit?
Yes ○ No ○

7.1.3 What hospital/team was the patient transferred to? *(this question is only available if 7.1 answered "Was transferred to an ESD/community team" or "Was discharged to an inpatient care setting")*

Enter team code

7.2. Date/time of discharge from stroke unit

dd mm yyyy hh mm

7.3. Date/time of discharge/transfer from team

dd mm yyyy hh mm

7.3.1 Date patient considered by the multidisciplinary team to no longer require inpatient care?

dd mm yyyy

7.4. Modified Rankin Scale score at discharge/transfer 0 - 6 *(defaults to 6 if 7.1 is died)*

7.5. If discharged to a care home, was the patient: Previously a resident ○ Not previously a resident ○
(this question will only be available if you answer "Was discharged to a care home" in 7.1)

7.5.1 If not previously a resident, is the new arrangement: Temporary ○ Permanent ○

7.6. If discharged home, is the patient:
Living alone ○ Not living alone ○ Not known ○
(this question will only be available if you answer "Was discharged home" in 7.1)

7.7. Was the patient discharged with an Early Supported Discharge multidisciplinary team?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○
(this question will only be available if you answer "Was transferred to an ESD/community team in 7.1")

7.8. Was the patient discharged with a multidisciplinary community rehabilitation team?
Yes, stroke/neurology specific ○ Yes, non-specialist ○ No ○
(this question will only be available if you answer "Was transferred to an ESD/community team in 7.1")

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

If yes:

7.9.1 What support did they receive?

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

7.9.2 At point of discharge, how many visits per week were social services going to provide?

0 - 100 or Not known ○

7.10. Is there documented evidence that the patient is in atrial fibrillation on discharge?
Yes ○ No ○

7.10.1 If yes, was the patient taking anticoagulation (not anti-platelet agent) on discharge or discharged with a plan to start anticoagulation within the next month?
Yes ○ No ○ No but ○

7.11. Is there documented evidence of joint care planning between health and social care for post discharge management?
Yes ○ No ○ Not applicable ○

7.12. Is there documentation of a named person for the patient and/or carer to contact after discharge?
Yes ○ No ○

7.13 Was COVID-19 confirmed at any time during the patient's hospital stay (or after death)?
Yes ○ No ○ Not known/not tested ○

7.13.1 If Yes, was COVID-19:
Present on admission (i.e. the admission COVID test was positive) ○
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 ○

Section 8: Six month (post admission) follow-up assessment

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 ○
N.B. 'No but' should only be answered for DNAs, patients who are not registered with a GP, or patients who have had another stroke and a new SSNAP record started

8.1.1 What was the date of 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 follow-up assessment:

GP	○	District/community nurse	○
Stroke coordinator	○	Voluntary Services employee	○
Therapist	○	Secondary care clinician	○
Other	○		

8.1.4 If other, please specify Free text (30 character limit)

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○

8.2 Was the patient screened for mood, behaviour or cognition since discharge using a validated tool?
Yes ○ No ○ No but ○
8.2.1 If yes, was the patient identified as needing support? Yes ○ No ○
8.2.2 If yes, has this patient received psychological support for mood, behaviour or cognition since discharge?
Yes ○ No ○ No but ○

8.3. Where is this patient living? Home ○ Care home ○ Other ○
8.3.1 If other, please specify Free text (30 character limit)

8.4. What is the patient's modified Rankin Scale score? 0 - 6

8.5. Is the patient in persistent, permanent or paroxysmal atrial fibrillation? Yes ○ No ○

8.6. Is the patient taking:

8.6.1	Antiplatelet:	Yes ○	No ○
8.6.2	Anticoagulant:	Yes ○	No ○
8.6.3	Lipid Lowering:	Yes ○	No ○
8.6.4	Antihypertensive:	Yes ○	No ○

8.7. Since their initial stroke, has the patient had any of the following:

8.7.1	Stroke	Yes ○	No ○
8.7.2	Myocardial infarction	Yes ○	No ○
8.7.3	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	○

8.8.1. Employment status currently:

Working full-time	○
Working part-time	○
Retired	○

Studying or Training ○
Unemployed ○
Other ○

8.9. EQ5D-5L score six months after stroke:

a. Mobility (1-5, 9 if missing) 1-5

b. Self-Care (1-5, 9 if missing) 1-5

c. Usual activities (work, study, etc.) (1-5, 9 if missing) 1-5

d. Pain/discomfort (1-5, 9 if missing) 1-5

e. Anxiety/Depression (1-5, 9 if missing) 1-5

f. How is your health today? (1-100, 999 if missing) 1-100

*8.1.5. 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.