# SCOTTISH STROKE CARE AUDIT

# OUTPATIENTS CORE DATASET

## DEFINITIONS AND VALUES

**Version 4.1 Reviewed November 2016**

**(For review November 2017)**

***NB: This form should be completed for all outpatient consultations including those held at alternative locations, e.g. A&E departments or Video Conference with Consultant in GP Practice.***

| **DATA ITEMS** *(30 excluding demographics)* | **DEFINITIONS** | **VALUES** *(Information required on proforma or options available on SSCAS)* |
|---|---|---|
| ***Demographics*** | | |
| CHI Number | Mandatory identifier. Community Health Index Number giving the patient a unique, national, reference number. (10 characters). | Enter 10 characters<br>*Consisting of the 6-digit date of birth (DDMMYY), two digits, a 9th digit which is always even for females and odd for males and an arithmetical check digit.*<br><br>If the patient has not been assigned a CHI then enter the date of birth (DDMMYY) and 0000 as the CHI, *e.g. if the patient's DOB is 12.08.1954 you would enter 1208540000*. **If the patient's CHI is allocated later you can go back into the Patient demographics and change the CHI.** |
| Date of Birth | Record the date the patient was born or officially deemed to have been born as recorded on the Birth Certificate. | Enter 8 characters *(DD/MM/CCYY)*<br>*NB: you must have a date of birth in order to create a patient, this field will not accept 'not recorded', 'unknown' etc.* |
| Gender | Record gender from drop down pick list.<br>A statement by the individual about the gender they currently identify themselves to be (i.e. self-assigned). | Enter male, female or not known |
| Surname | "The surname of a person represents that part of the name of a person which indicates the family group of which the person is part." (From the Core Patient Profile Information in Scottish Hospitals (COPPISH) SMR Data Manual Version 1.1; issued November 1995 p2-5) | Enter surname |
| Forename | "The first forename of a person represents that part of the name of a person which, after the surname, is the principal identifier of a person." (From the COPPISH SMR Data Manual version 1.1; issued November 1995 p2-6)<br>When recording names be aware of different conventions for order for parts of the name used in different cultures. | Enter forename |

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| Patient Postcode | Record complete postcode of patient's normal permanent place of residence, e.g. home, nursing home, NHS continuing care etc. at time of current cerebrovascular event.<br>If the patient is already in hospital for temporary short term care their normal permanent place of residence postcode should be used and not that of the hospital where they are temporarily an inpatient.<br>**If the patient <u>does not have a UK postcode</u> select code from drop down pick list (COPPISH codes).** | Patients <u>with</u> UK postcode – enter full postcode (up to 8 digits)<br>Patients <u>without</u> UK postcode – enter appropriate code from list below:<br>*NK010AA - Address not known*<br>*NF11AB - No fixed abode*<br>*OS14AA - Overseas visitor from EIRE*<br>*OS16AA - Overseas visitor from The Commonwealth*<br>*OS17AA - Overseas visitor from British Dependent Territory*<br>*OS18AA - Overseas visitor from Other Foreign Country* |
| Ethnicity | Record the patient's ethnic origin - a statement made by the service user re their current ethnic group.<br>From the COPPISH data manual.<br>All boards have a requirement to collect ethnicity data routinely.<br>If ethnicity is not clearly documented in the patient's notes, enter 'not known'.<br><br>*NB: The ethnicity coding list held within eSSCA is updated automatically and the SSCA central team have no control over this. The list presented in this document is correct at 23.10.2013.* | Pick list: enter either:<br>African, African Scottish or African British<br>Any mixed or multiple ethnic groups<br>Any other white ethnic group<br>Arab, Arab Scottish or Arab British<br>Bangladeshi, Bangladeshi Scottish or Bangladeshi British<br>Black, Black Scottish or Black British<br>Caribbean, Caribbean Scottish or Caribbean British<br>Chinese, Chinese Scottish or Chinese British<br>Gypsy/ Traveller<br>Indian, Indian Scottish or Indian British<br>Irish<br>Not known<br>Not recorded<br>Other African<br>Other Asian, Asian Scottish or Asian British<br>Other British<br>Other Caribbean or Black<br>Other ethnic group<br>Pakistani, Pakistani Scottish or Pakistani British<br>Polish<br>Refused/ Not provided by patient<br>Scottish |
| GP, Practice Address and Practice Code *(with branch code as appropriate)* | Record GP practice name/ address - selecting the GP practice using the search facility in eSSCA will automatically populated the GP Practice field.<br>GP practice is defined as – GP/ practice patient registered with at time of current cerebrovascular event.<br>*(Information stored will include GP name, address, practice code, branch code (if appropriate) and GMC number)*<br><br>If the patient's <u>GP is from out with Scotland</u> enter the GPs name and address in the text fields available.<br>*(Information stored will be name and address only)*<br><br>If the patient's GP is not known or they are not registered with a GP, or they are from out with the UK enter the appropriate text. | Drop down pick list<br><u>Scottish GP Practices</u> – Search facility – search using key words or preferably GP practice code if that is known.<br>One or more GP practices will appear. Click on the appropriate practice, this will automatically populate the GP practice field.<br><br><u>Non-Scottish GP</u> - enter the GPs name and address in the appropriate text fields. |

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| GP Name | Select the GP's name from a pre-populated list. If the GP Name is not on the list, select Other and enter the GP Name in the text field. *NB: You must select GP Practice before selecting the GP Name.* | Drop down pick list. This list is pre-populated with all GPs at the selected GP Practice. If the GP Name is not on the list, select Other and enter the GP Name in the text field. |
| Other GP Practice | If the patient's GP is from out with Scotland enter the GP Practice name and address. | Text field: enter the GP Practice Name and address |
| Other GP | If the patient's GP is from out with Scotland enter the GP name. | Text field: enter the GP's name. |

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| ***Patient Pathway*** | | |
| **1. Date of first attendance at clinic (or seen by stroke team in A&E)** | **Record the date the patient first attended for an outpatient appointment or was reviewed by the stroke team in A&E, as an outpatient and discharged home.** | **Enter date *(DD/MM/CCYY)***<br><br>**Enter 8 characters (DDMMCCYY)**<br>**You do not need to enter the "/"**<br>**If date is not recorded then enter 07/07/0707.**<br>**If date is unknown then enter 08/08/0808.**<br>**If the date is illegible then enter 09/09/0909.** |
| 2. Consultant responsible for care during attendance at outpatient clinic/ review in A&E | Record the consultant under whose care the patient was whilst attending the outpatient clinic or the name of the consultant who reviewed the patient in A&E as an outpatient and discharged them.<br>If consultant is not documented in the patient's records, enter 'not recorded'.<br>*(Information stored is the consultant's GMC number)* | Drop down pick list of responsible clinicians, includes options of – GP, Not applicable and Other. The list will by sorted by Health Board with the User's Health Board at the top of the list. Retired/inactive consultants names are prefixed with an * and included at the bottom of the list.<br><br>*(NB: Please contact the SSCA central team if you require a consultant to be added or removed from this list)* |
| 3. Where was the patient seen as an 'outpatient'? | Enter the type of facility where the patient was seen as an 'outpatient'. | Enter clinic, A&E or Other (specifying other in the available text field) |
| 4. Unit where seen | Enter the name of the clinic, A&E unit or other area where the patient was seen/ reviewed as an 'outpatient'. | Drop down pick list of hospitals from an SSCA Reference File including Private hospital, Other hospital, Hospital out with Scotland and Unknown.<br>Hospitals from the User's Health Board will appear at the top of the list.<br>*(NB: Please contact the SSCA central team if you require a hospital to be added or removed from this list)* |
| 5. Date of referral | Record the date of the first referral made to outpatient clinic. | Enter date *(DD/MM/CCYY)*<br><br>Enter 8 characters (DDMMCCYY)<br>You do not need to enter the "/"<br>If date is not recorded then enter 07/07/0707.<br>If date is unknown then enter 08/08/0808.<br>If the date is illegible then enter 09/09/0909. |
| 6. Source of referral | Record the source of the referral. | Drop down pick list of referral sources *General Practitioner (GP), Medical assessment (MA), Accident and emergency (A&E), Acute receiving unit (ARU), Combined assessment, Outpatient clinic, Out of hours service (OOH), Inpatient episode (ward) Ophthalmology, Transfer from other hospital, Other (specifying other in the available text field), Unknown, Not recorded or Ambiguous/ illegible* |

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| **7. Date referral received** | **Record the date the referral is received by the hospital/ clinic or referral management service (either by post, fax or electronically).** | **Enter date *(DD/MM/CCYY)***<br><br>**Enter 8 characters (DDMMCCYY)**<br>**You do not need to enter the "/"**<br>**If date is not recorded then enter 07/07/0707.**<br>**If date is unknown then enter 08/08/0808.**<br>**If the date is illegible then enter 09/09/0909.** |
| 8. Date of first appointment offered | Record the date of the first outpatient appointment offered to the patient.<br>The service may offer the patient an appointment that they cannot attend and therefore have to reschedule. The initial appointment may meet the current standard though subsequent appointment would not. | Enter date *(DD/MM/CCYY)*<br><br>Enter 8 characters (DDMMCCYY)<br>You do not need to enter the "/"<br>If date is not recorded then enter 07/07/0707.<br>If date is unknown then enter 08/08/0808.<br>If the date is illegible then enter 09/09/0909. |
| 9. Was the patient referred for a carotid intervention? | Record whether the patient was referred for carotid intervention. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 10. Did the patient have a carotid intervention? | Record whether the patient has had a carotid intervention.<br><br>***NB: If the patient has had carotid intervention relevant additional form should be completed***<br>*If the patient has a carotid intervention, i.e. 'Yes' entered eSSCA will automatically monitor that a carotid form is completed for this patient and will not allow the user to close the outpatient form without a carotid form linked to it.* | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |

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| ***Diagnosis*** | | |
| 11. Is the most likely diagnosis non-cerebrovascular? | If entering yes to this question **there is no need to complete the rest of this form.**<br>The final diagnosis may be taken from the outpatient notes or clinic letter. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 11a. Non-cerebrovascular diagnosis | If answered yes to Q11 enter diagnosis.<br>The final diagnosis may be taken from the outpatient notes or clinic letter. | Migraine, Epileptic seizure, Syncope/ Presyncope (faint), Tumour, Subdural haematoma, Psychological, e.g. panic attack, Not recorded, Unknown, Ambiguous/ Illegible or (11b) Other (specifying other) |
| ***If the answer to the question above is 'yes' there is no need to complete the remainder of this form.*** | | |
| 12. Do you want to enter further form details? | If the answer to Q11 is yes, there is no need to complete the rest of the form.<br>The user should enter 'No' to Q12 and eSSCA will grey out the remaining fields. | Enter Yes or No |
| 13. Date of **most recent** cerebral TIA/ stroke/ eye attack which led to referral to the NV clinic. | Record the date of the **most recent** TIA/ stroke/ eye attack which led to the current referral to outpatients. | Enter date *(DD/MM/CCYY)*<br><br>Enter 8 characters (DDMMCCYY)<br>You do not need to enter the "/"<br>If date is not recorded then enter 07/07/0707.<br>If date is unknown then enter 08/08/0808.<br>If the date is illegible then enter 09/09/0909. |
| 14. Is stroke the most likely diagnosis? | Record yes if the stroke diagnosis has been documented as either definite (meaning no reasonable alternative) or probable (meaning any alternative is less likely than stroke), or in any circumstance where stroke is considered the most likely diagnosis.<br>It may be necessary in some instances to code both stroke and TIA and this is acceptable.<br>The final diagnosis may be taken from the outpatient notes or clinic letter.<br>If the final diagnosis is recorded as 'uncertain' or 'unclear' enter 'unknown' in this field.<br>*NB: We are no longer collecting information relating to Subarachnoid Haemorrhage (SAH), this would be treated as an 'overriding diagnosis' and the patient would not be included in the audit.* | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 15. Stroke pathology | Record the stroke pathology, e.g. ischaemic, haemorrhagic etc. | Drop down pick list<br>*Ischaemic, Haemorrhagic, Haemorrhagic transformation of infarct, Uncertain or Not recorded* |
| 16. Is cerebral TIA the most likely diagnosis? | Record yes if the TIA diagnosis has been documented as either definite (meaning no reasonable alternative) or probable (meaning any alternative is less likely than TIA), or in any circumstance where TIA is considered the most likely diagnosis.<br>It may be necessary in some instances to code both stroke and TIA and this is acceptable.<br>The final diagnosis may be taken from the outpatient notes or clinic letter.<br>If the final diagnosis is recorded as 'uncertain' or 'unclear' enter 'unknown' in this field. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |

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| 17. Was monocular blindness, duration ≥ 24 hrs (Retinal Artery Occlusion (RAO)) the most likely diagnosis? | Record yes if the RAO diagnosis has been documented as either definite (meaning no reasonable alternative) or probable (meaning any alternative is less likely than RAO), or in any circumstance where RAO is considered the most likely diagnosis.<br>The final diagnosis may be taken from the outpatient notes or clinic letter.<br>If the final diagnosis is recorded as 'uncertain' or 'unclear' enter 'unknown' in this field. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 18. Was monocular blindness, duration <24 hrs (Transient Monocular Blindness (TMB)) the most likely diagnosis? | Record yes if the TMB diagnosis has been documented as either definite (meaning no reasonable alternative) or probable (meaning any alternative is less likely than TMB), or in any circumstance where TMB is considered the most likely diagnosis.<br>The final diagnosis may be taken from the outpatient notes or clinic letter.<br>If the final diagnosis is recorded as 'uncertain' or 'unclear' enter 'unknown' in this field. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| ***History*** | | |
| 19. Does the patient have a past medical history of Atrial Fibrillation or Atrial Flutter? | Record whether the patient has a clear past medical history of Atrial Fibrillation or Atrial Flutter (either permanent or temporary) documented in their records (at any time). | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 20. Was the patient on anticoagulation, e.g. Warfarin, at onset of current cerebrovascular event or involved in a relevant clinical trial? | Record yes if the patient was on any of the following prior to **and** at the time of first symptoms:<br>Warfarin<br>Rivaroxaban<br>Apixaban<br>Treatment dose heparin > 15 000 units/ day<br>Enoxaparin (LMWH) > 40 units/ day<br>Tinzaparin (LMWH) > 5000 units/ day<br>Dalteparin (LMWH) > 5000 units/ day<br>Bemiparin (LMWH) > 5000 units/ day<br>Fondaparininux (LMWH) > 2.5mgs/ day<br>Direct thrombin inhibitor, e.g. Dabigatran Etexilate (Pradaxa®)<br>If the patient was involved in a relevant clinical trial of anticoagulants the answer would also be yes.<br><br>Record No if on:<br>Standard heparin ≤ 15 000 units/ day<br>Enoxaparin (LMWH) ≤ 40 units/ day<br>Tinzaparin (LMWH) ≤ 5000 units/ day<br>Dalteparin (LMWH) ≤ 5000 units/ day<br>Bemiparin (LMWH) ≤ 5000 units/ day<br>Fondaparininux (LMWH) ≤ 2.5mgs/ day<br><br>NB: Anticoagulation does NOT include Aspirin, Clopidogrel or Dipyridamole.<br>*This is a question related to patient management; please ignore complications relating to compliance.* | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| ***Investigations*** | | |
| 21. Has brain imaging been done since current event? | Record if brain imaging (CT or MRI scan) has been done since cerebrovascular event which led to current referral to outpatient clinic. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |

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|---|---|---|
| 22. Date of first brain imaging for current event | Record the date of the first brain imaging done since cerebrovascular event which led to current referral to outpatient clinic.<br>*(NB:*<br>*- Date of imaging that predates clinic attendance will be accepted, e.g. if the patient has a scan at the eye clinic prior to attending the outpatient clinic.*<br>*- This information may not be available electronically.*<br>*- Dates/ timings on scanners/ imagers may be inaccurate - co-ordinators will need to confirm that the clock timings on machines are correct by consulting with their radiology colleagues.*<br>*- The date/ time on the imaging report may be the time it was requested. The time on the actual scan is likely to be the correct time, i.e. the time the scan was carried out).* | Enter date *(DD/MM/CCYY)*<br><br>Enter 8 characters (DDMMCCYY)<br>You do not need to enter the "/"<br>If date is not recorded then enter 07/07/0707.<br>If date is unknown then enter 08/08/0808.<br>If the date is illegible then enter 09/09/0909. |
| 23. Has imaging of Internal Carotid Artery (ICA) stenosis been performed since current event? | Record yes if ICA imaging has been performed since cerebrovascular event which led to current referral to outpatient clinic, e.g. carotid doppler/ ultrasound/ Duplex, CT angiogram (CTA), MR angiogram (MRA) or intra arterial angiography. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 24. Date of first imaging of ICA for current event | Record date of first imaging of ICA for cerebrovascular event which led to current referral to outpatient clinic.<br>*NB: Date of imaging that predates clinic attendance will be accepted, e.g. if the patient has imaging of ICA recorded prior to attending the outpatient clinic.* | Enter date *(DD/MM/CCYY)*<br><br>Enter 8 characters (DDMMCCYY)<br>You do not need to enter the "/"<br>If date is not recorded then enter 07/07/0707.<br>If date is unknown then enter 08/08/0808.<br>If the date is illegible then enter 09/09/0909. |
| 25. Was atrial fibrillation or atrial flutter confirmed at outpatient appointment? | Record yes if atrial fibrillation or atrial flutter was demonstrated on ECG (or 24 hour tape or echocardiogram) at time of first assessment at outpatient clinic.<br>Also record yes if outpatient clinician confirms AF on ECG sent in by GP? | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| ***Medication*** | | |
| 26. Was the patient on Aspirin at 1st assessment? | Record yes if the patient was on aspirin or was involved in a clinical trial of aspirin at 1st assessment at the outpatient clinic | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 27. Was the patient on another antiplatelet instead of or in addition to Aspirin at 1st assessment? | Record yes if the patient was was on another antiplatelet, e.g. Clopidogrel or Dipyridamole instead of or in addition to Aspirin or was involved in a clinical trial of antiplatelet(s) at 1st assessment at the outpatient clinic. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 28. Was Aspirin continued, commenced, or recommended at 1st assessment? | Record yes if Aspirin was continued, commenced or recommended or if the patient was enrolled in a clinical trial of Aspirin at 1st assessment at the outpatient clinic. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |

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|---|---|---|
| 29. Was another antiplatelet continued, commenced or recommended at 1st assessment? | Record yes if another antiplatelet, e.g. Clopidogrel or Dipyridamole was continued, commenced or recommended or if the patient was enrolled in a clinical trial of antiplatelet(s) at 1st assessment at the outpatient clinic. | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |
| 30. Was anticoagulation, e.g. Warfarin or other anticoagulant commenced, continued or recommended at 1st assessment? | Record yes if the patient was on any of the following prior to **and** at the time of first symptoms:<br>Warfarin<br>Rivaroxaban<br>Apixaban<br>Treatment dose heparin > 15 000 units/ day<br>Enoxaparin (LMWH) > 40 units/ day<br>Tinzaparin (LMWH) > 5000 units/ day<br>Dalteparin (LMWH) > 5000 units/ day<br>Bemiparin (LMWH) > 5000 units/ day<br>Fondaparininux (LMWH) > 2.5mgs/ day<br>Direct thrombin inhibitor, e.g. Dabigatran Etexilate (Pradaxa®)<br>If the patient was involved in a relevant clinical trial of anticoagulants the answer would also be yes.<br><br>Record No if on:<br>Standard heparin ≤ 15 000 units/ day<br>Enoxaparin (LMWH) ≤ 40 units/ day<br>Tinzaparin (LMWH) ≤ 5000 units/ day<br>Dalteparin (LMWH) ≤ 5000 units/ day<br>Bemiparin (LMWH) ≤ 5000 units/ day<br>Fondaparininux (LMWH) ≤ 2.5mgs/ day<br><br>NB: Anticoagulation does NOT include Aspirin, Clopidogrel or Dipyridamole.<br>*This is a question related to patient management; please ignore complications relating to compliance.* | Enter Yes, No, Not recorded, Unknown, Ambiguous/ illegible. |