**SCOTTISH STROKE CARE AUDIT**

**DATA COLLECTION QUICK NOTES**

Version 4.0 Updated December 2013
(For review November 2017)

1a. **Patients to be included in the audit** (Inpatient form)
All patients with stroke or TIA as the most likely diagnosis on admission to hospital should be included in the SSCA inpatient audit.

Data are collected prospectively and every patient admitted with stroke or TIA as the most likely diagnosis should receive appropriate care as per the Scottish Stroke Care Standards until a diagnosis of stroke is ruled out. It should also be noted that it has been agreed that we should not attempt to audit second strokes occurring in hospital.

If the initial diagnosis of stroke changes to another over-riding diagnosis (e.g. brain tumour) you should enter the date of discharge as the date of the over-riding diagnosis and there is no requirement to complete the remainder of the inpatient form. However, in order to commit (close) the form in eSSCA you are required to enter ‘not recorded’, ‘unknown’ or ‘ambiguous/illegible’ in the remaining fields.

(For further guidance see Flow Chart, Appendix A)

NB: If you have answered ‘Yes’ to Q11 (Was thrombolysis given or clot retrieval performed?) eSSCA will not allow you to commit the inpatient form without having a linked thrombolysis form.

Likewise if you have answered ‘Yes’ to Q56 (Did the patient have a carotid intervention?) eSSCA will not allow you to commit the inpatient form without having a linked carotid intervention form.

1b. **Patients to be included in the audit** (Outpatient form)
All new patients attending neurovascular outpatient clinic with a preliminary diagnosis of stroke/ TIA.

Data are collected prospectively and every patient should receive appropriate care as per the Scottish Stroke Care Standards.

If after review at the clinic the most likely diagnosis is non-cerebrovascular (i.e. Q11 = Yes) enter the non-cerebrovascular diagnosis (from the available options in Q11a), answer ‘No’ to Q12 (Do you want to enter further form details) and you do not need to complete the rest of the form.

NB: If you have answered ‘Yes’ to Q10 (Did the patient have a carotid intervention?) eSSCA will not allow you to commit the outpatient form without having a linked carotid intervention form.

1c. **Patients to be included in the audit** (Thrombolysis form)
All patients who receive thrombolysis treatment.

This form is linked to the inpatient form. Data are collected prospectively and every patient should receive appropriate care as per the Scottish Stroke Care Standards.

NB: eSSCA will not allow you to commit the thrombolysis form without having linked it to an inpatient form.

1d. **Patients to be included in the audit** (Carotid Intervention form)
All patients who have a carotid intervention performed. This form could be linked to an inpatient or outpatient form or could be a stand alone form.

We are auditing all patients referred for Carotid Intervention through the stroke service in the first instance. You may need to consult with clinical teams when completing the Carotid Intervention form.

Data are collected retrospectively.
There is an option to collect only part of the carotid intervention dataset. If you answer ‘No’ to Q16 (Do you want to complete the remainder of this form?) the remainder of the form will be greyed out and will not affect validations when you commit the form.

Information on the second part of the form may be difficult to find and it is at the discretion of the MCN/local clinical team if the Audit Coordinators collect these data locally.

For the purposes of SSCA we will measure time from the event that first led to the patient seeking medical attending to intervention date only as per the requirements of the Scottish Stroke Care Standard.

There may be some asymptomatic patients requiring a carotid intervention, again it is at the discretion of the MCN if these patients data are collected. The Scottish Stroke Care Standard relates to symptomatic patients. SSCA will analyse and report on the carotid pathway and outcomes for symptomatic patients.

2. Adding patients with no CHI number to eSSCA
If a patient has not been assigned a CHI number (e.g. visitor from out with Scotland) then enter their date of birth (DDMMYY) and four zeros (0000) as the CHI number (referred to as a ‘dummy CHI’), e.g. if the patient’s DOB is 12.08.1954 you would enter 1208540000.

It is important to note that if the patient’s CHI is allocated at a later date the user should go back into the Patient demographics and amend the CHI number so that the patient can be found on the system at a later date.

3. Pick List for Ethnicity (Inpatient and Outpatient forms)
The following pick list is available on Inpatient and Outpatient Forms for ethnicity recording

<table>
<thead>
<tr>
<th>DATA ITEM</th>
<th>CODE/ PICK LIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnicity</td>
<td>African, African Scottish or African British</td>
</tr>
<tr>
<td></td>
<td>Any mixed or multiple ethnic groups</td>
</tr>
<tr>
<td></td>
<td>Any other white ethnic group</td>
</tr>
<tr>
<td></td>
<td>Arab, Arab Scottish or Arab British</td>
</tr>
<tr>
<td></td>
<td>Bangladeshi, Bangladeshi Scottish or Bangladeshi British</td>
</tr>
<tr>
<td></td>
<td>Black, Black Scottish or Black British</td>
</tr>
<tr>
<td></td>
<td>Caribbean, Caribbean Scottish or Caribbean British</td>
</tr>
<tr>
<td></td>
<td>Chinese, Chinese Scottish or Chinese British</td>
</tr>
<tr>
<td></td>
<td>Gypsy/ Traveller</td>
</tr>
<tr>
<td></td>
<td>Indian, Indian Scottish or Indian British</td>
</tr>
<tr>
<td></td>
<td>Irish</td>
</tr>
<tr>
<td></td>
<td>Not known</td>
</tr>
<tr>
<td></td>
<td>Not recorded</td>
</tr>
<tr>
<td></td>
<td>Other African</td>
</tr>
<tr>
<td></td>
<td>Other Asian, Asian Scottish or Asian British</td>
</tr>
<tr>
<td></td>
<td>Other British</td>
</tr>
<tr>
<td></td>
<td>Other Caribbean or Black</td>
</tr>
<tr>
<td></td>
<td>Other ethnic group</td>
</tr>
<tr>
<td></td>
<td>Pakistani, Pakistani Scottish or Pakistani British</td>
</tr>
<tr>
<td></td>
<td>Polish</td>
</tr>
<tr>
<td></td>
<td>Refused/ Not provided by patient</td>
</tr>
<tr>
<td></td>
<td>Scottish</td>
</tr>
</tbody>
</table>

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.

4. Patient Postcode (All forms)
For patients without a UK postcode, enter one of the following options.
NK010AA - Address not known
NF11AB - No fixed abode
OS14AA - Overseas visitor from EIRE
OS16AA - Overseas visitor from The Commonwealth
OS17AA - Overseas visitor from British Dependent Territory
OS18AA - Overseas visitor from Other Foreign Country
5. GP and GP Practice (All forms)
The list of GP practices 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.

NB: Search for the GP practice by using practice code where possible as this should return only one
option. Otherwise search using name of practice, town or postcode. It may be that you have to try
several options depending on how the practice is listed, e.g. some will not have a town in the address
just the name of the practice and the postcode.

You must populate the practice field before attempting to add a GP. Once the practice is found, the list of
associated GPs will appear in the drop down menu. You must select a GP otherwise the details will not
appear on the patient’s electronic record.

6. Dates (All forms)
Dates can be entered into eSSCA in two ways:

6.1 By **typing the date directly into the date field**. Dates should be entered using an eight digit date
e.g. 20061966.

**NB:** Errors may occur if the user enters a six digit date, in particular for those dates pre 1950. If the user
only enters a six digit date e.g. 200649, the system will change the date to 20/06/2049. Committing a
form with this date entered will trigger an error message as the date is incorrect.
Errors may also occur if the user enters a seven digit date, e.g. 2061949, the system will change the
date to 02/06/1949. This will be accepted in the first instance as is a correct date.

6.2 By **using the calendar function** at the right side of the date fields. Using the calendar function:
To select a month - use either the drop down menu or the left/ right arrows at the top of the box to select
the month required.
To select a year - use the drop down menu to select the year required. If the year required precedes the
years shown, click on the earliest year to reveal a further 20 years.
To select a date - click on the relevant date from the calendar shown (NB: today’s date is shown in red).

All dates require 8 digit entries either manually or using the calendar function.

- If the date is not recorded enter either 07070707
- If the date is unknown enter 08080808
- If the date is ambiguous/ illegible enter either 09090909

**Key Dates:**
The four forms included in eSSCA have specific 'key dates'. These dates are required for reporting. The
key dates are:
- Inpatients - Date admitted for Stroke Care
- Thrombolysis - Date when thrombolysis treatment started
- Outpatients - Date of 1st attendance at clinic
- Carotid Intervention - Date of carotid intervention

7. Times (All forms)
Times should be entered in 24 hour format, i.e. 1600

All times require 4 digit entries.

- If the time is not recorded enter either 7777
- If the time is unknown enter either 8888
- If the time is ambiguous/ illegible enter either 9999

8. Field choices (All forms)
All fields including those for Yes, No etc. are drop down boxes (containing menu options). Select the option you require. If an ‘other’ option is selected there will usually be an option to enter a text description (but not always, if this information is deemed unnecessary).

9. First hospital (Inpatient form)
This is the first hospital the patient attends, e.g. if the patient attends Caithness Hospital and then is transferred and admitted to Raigmore Hospital – Caithness would be 1st hospital and Raigmore would be the admitting hospital, even if they only reach A&E at the first hospital.

10. Admitting hospital (Inpatient form)
This is the hospital where the patient is admitted for acute stroke care, e.g. if the patient attends A&E at the Royal Infirmary in Edinburgh and is transferred to the Western General Hospital for acute stroke care – the Western General Hospital would be the admitting hospital.

NB: On eSSCA once the admitting hospital is entered, all the remaining location fields on the inpatient form (other than Stroke Rehabilitation Unit) will default to this.

11. Where procedures were performed (Inpatient form)
You are required in eSSCA to enter where procedures were performed, e.g. brain imaging, carotid doppler, swallow screen and aspirin prescribing.
As noted above, once the admitting hospital is entered, all the remaining location fields on the inpatient form (other than Stroke Rehabilitation Unit) will default to this.

12. Uncertain/ unclear diagnosis (Inpatient form)
If following initial investigation the diagnosis is still recorded as ‘unclear’ or ‘uncertain’ then unknown should be entered for the purposes of the audit. If the patient is not being treated as a stroke then they should be removed from the audit at this stage and a discharge date entered.

13. Discharge date (Inpatient form)
Record the discharge date at the end of active care for that stroke event. This will include active acute care and any period of stroke rehabilitation including that undertaken in a general rehabilitation unit.

If the patient:
- Is being transferred for NHS continuing care or transferred to a ‘boarding bed’ whilst awaiting discharge, the date of transfer should be used as the discharge date (again only discharge from the audit if all active care for that stroke event is complete – if the patient is ‘boarded’ but still requires active stroke care they should remain in the audit).
- If the patient has another acute episode with overriding diagnosis the date of discharge would be the date of that event, e.g. the patient has a myocardial infarction and is transferred to the coronary care unit, or if the patient has a further stroke and is transferred back to the acute/integrated stroke unit.
- Patients readmitted to the acute/integrated stroke unit with a second stroke (following discharge) would re-enter the audit and a new form would be started.
- If the patient has died, the date discharged from stroke care will be the date of death.

14. Patients who are transferred and/ or admitted to more than one hospital (Inpatient form)
If a patient is admitted to more than one Stroke Unit and has a different consultant, this information needs to be added to eSSCA. If more than one Stroke Unit is entered entry and exit dates will also be required.
You are also able to transfer the patient between Health Boards within the system. (Additional information is available in the eSSCA supporting documentation).

15. Referred for thrombolysis (Inpatient form)
This information is for local use only and will not be analysed centrally. It was noted that centres would be interested to look at how many patients were referred for thrombolysis and how many had procedures.
If the patient has thrombolysis, i.e. ‘Yes’ entered in Q11 on the inpatient form there will however be cross form validation within eSSCA to ensure that if you have said thrombolysis has been performed there is a linked thrombolysis form.

16. First attendance at clinic (Outpatient form)
An additional field has been added to the outpatient form to indicate where the patient was assessed as an outpatient, e.g. patients may not necessarily be seen in an actual clinic, but may be reviewed in A&E or the ward as an outpatient.

17. Non-cerebrovascular diagnosis (Outpatient form)
This information is for local use only and will not be analysed centrally. It was noted that centres would be interested to look at how many non-stroke patients were being seen in outpatient clinics. **NB: There is also the option to select the non-cerebrovascular diagnosis.**

18. Referred for carotid intervention (Inpatient and Outpatient form)
This information is for local use only and will not be analysed centrally. It was noted that centres would be interested to look at how many patients were referred for carotid intervention and how many had procedures.
If the patient has a carotid intervention, i.e. ‘Yes’ entered in on the inpatient (Q56)/outpatient (Q10) there will however be cross form validation within eSSCA to ensure that if you have said a Carotid Intervention has been performed there is a linked carotid form.

19. Additional forms
- Thrombolysis – this form should be completed in addition to the Inpatient form for all patients who have undergone thrombolysis.
- Carotid Intervention – this form should be completed in addition to the Inpatient/Outpatient form for all patients who have undergone a Carotid Intervention. **NB. This may include patients who have not presented via the stroke care pathway and therefore may be completed independently.**
APPENDIX A
Inpatient Flow Chart demonstrating inclusion in the SSCA?

This flow chart has been designed to clarify which patients should be included in the inpatient SSCA. It should also be noted that it has been agreed that we should not attempt to audit second strokes occurring in hospital.

Version 2.0 (updated December 2013)

**FIRST DIAGNOSIS MADE IN HOSPITAL MENTIONS STROKE OR TIA**

**YES**

Stroke or TIA is the most likely diagnosis

**YES**

Stroke specialist at their initial clinical assessment confirms likely diagnosis of stroke or TIA

**NO**

If the diagnosis of stroke or TIA is not the most likely

**NO**

Clinical diagnosis of stroke or TIA is rejected by stroke specialist at initial clinical assessment

**DISCHARGE FROM THE AUDIT**

If the diagnosis of stroke or TIA is an *old* diagnosis

**DO NOT INCLUDE IN THE AUDIT**

*NB: Brain imaging at a later date may confirm stroke/ TIA and the patient would then be included in the audit*

**DO NOT INCLUDE IN THE AUDIT**

If the diagnosis of stroke or TIA is not the most likely

**YES**

Brain imaging

**YES – Include in Audit**

Stroke or TIA confirmed as main diagnosis following brain imaging

**NO**

Other diagnosis confirmed (e.g. brain tumour)

**NO**

Stroke or TIA AND over-riding diagnosis confirmed

**YES**

Despite inconclusive imaging, Stroke or TIA remains the most likely diagnosis

**YES – Include in Audit**

Audit the stroke pathway (i.e. complete the inpatient proforma including any relevant User Defined Fields)

**DISCHARGE FROM THE AUDIT**

Once all stroke care for that stroke is complete

**NB: All other patients with a final diagnosis of stroke/ TIA should also be included in the audit.**

**When discharging a patient from the audit, complete the following fields:**

1. **Discharge date** - Record the date the decision was made that the patient has an ‘other’ or ‘over-riding’ diagnosis or all active care for that stroke event is completed. This will include acute care and any period of stroke rehabilitation including that undertaken in a general rehabilitation unit.

If the patient is being transferred for NHS continuing care or transferred to a ‘boarding bed’ whilst awaiting discharge the date of transfer should be used as the discharge date (again only discharge from audit if all active care for that stroke event is complete – if the patient is ‘boarded’ but still requires active stroke care they should remain in the audit).

2. **Discharged to** - Record the type of place the patient was discharged to. If they are discharged from the audit due to an ‘other’ or ‘over-riding’ diagnosis, select the appropriate descriptor, i.e. ‘other diagnosis’ or ‘over-riding diagnosis’.

*For further details please refer to the inpatient data definitions document*