# SCOTTISH STROKE CARE AUDIT

## Audit guidelines and data definitions

Updated and circulated (January 2023)
For use on audit cases admitted from 1st February 2023

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# 1. General guidance

### 1.1 Audit group

People who have had or are suspected to have had a stroke or transient ischaemic attack (TIA).

### 1.2 Inclusion criteria

All patients aged 16 years or older who present with a rapid onset of neurological deficits, which are most often focal, and after appropriate consideration by the clinical team treating the patient thought to be due to a recent cerebral infarct (whether visualised on brain imaging or not) or intracerebral haemorrhage confirmed on brain imaging.

Include patients with an intracerebral haemorrhage which turns out to be due to an underlying vascular formation, tumour or abnormality of haemostasis.

Include all patients admitted to your hospital with stroke or TIA as the most likely diagnosis (either initial or final).

Include patients who are current inpatients in any ward, who have a rapid onset of neurological deficits resulting in stroke or TIA as the most likely diagnosis.

Include patients who attend the emergency department (ED) but die prior to ward admission or treatment.

If the patient has a subsequent stroke whilst already in hospital being treated for a stroke, do not audit the second event.

Data are collected prospectively, and every patient admitted with a 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.

If the initial diagnosis of stroke changes to another overriding diagnosis (e.g., brain tumour), enter the date of discharge as the date of the overriding diagnosis. There is no requirement to complete the remainder of the inpatient form but, in order to commit the form in eSSCA, you will need to enter ‘unknown’ in the remaining fields. For further guidance, please refer to Inpatient Flow Chart, Appendix A, at the end of this document.

NB. If you have answered ‘Yes’ to Q11 (Was thrombolysis given?) eSSCA will not allow you to commit the inpatient form without having a linked thrombolysis form. For patients who have clot retrieval performed, thrombectomy centre Local Audit Coordinators (Ninewells, Queen Elizabeth University Hospital, Royal Infirmary Edinburgh) will collect and enter the clot retrieval audit information into the Research Electronic Data Capture (REDCap) system.

NB. 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.

Patients should be entered into the audit by the admitting hospital.

### 1.3 Exclusion criteria

Exclude patients who have:

- Infarcts affecting their spinal column
- Those with infarcts on brain imaging which are not thought to have had any clinical effect
- Intracerebral haemorrhages due to trauma, including surgery (if a patient has a haemorrhage as a result of an operation for a cerebral tumour or vascular formation this should be excluded as it would be deemed traumatic)
- A subarachnoid haemorrhage - unless this is secondary to an intracerebral haemorrhage
- Subdural or extra dural haematomas
- Asymptomatic micro bleeds
- Dissection (this should be excluded if dissection only and without a stroke diagnosis)
- Patients who have their stroke out with Scotland

When excluding someone from the audit based on neurological event type, please ensure the diagnosis can be corroborated from several sources e.g., discussion with stroke consultant/ clinical team, brain scanning reports and clinical notes. This helps to ensure that people are excluded based on a robust diagnosis.

### 1.4 Patient identification

The Scottish Stroke Care Audit has approval from the data protection officer at Public Health Scotland to collect limited personal information on the patients included in the audit.

### 1.5 Audit methodology

Complete a proforma for every eligible patient with a likely diagnosis of stroke or TIA admitted to hospital. Patients should only be lost to audit in exceptional circumstances and the Local Audit Coordinators (LAC) should make every effort to access the notes for patients even if their attendance was when the LAC was on leave.

For patients who are transferred between hospitals and across health boards, each LAC should only complete the relevant information in eSSCA during the time the patient is with them. No changes to data entered by the transferring hospital LAC should be made without discussing this with them to ensure the correct information is being audited.

### 1.6 Submission process

Once the patient is discharged from the audit, their eSSCA record must be closed as soon as possible. If you are still waiting on audit information once the patient has been discharged from the audit, you need to record any missing fields as not known (if you have been unable to see the patients notes) or not recorded (if you have seen the patients notes and the required information is not there) and close the record. If, at a later date, the required data are available, the record can be reopened, and the data updated.

By the 31st of March you are required to close all records from the previous year as the annual report is based on closed data. If the patient is still an inpatient under stroke care, code the date of discharge and destination as unknown and close the record. Once the information is known, you can ask for the record to be reopened to update.

### 1.7 eSSCA guidance notes

### 1.71 Changes to patient demographics

To change patient demographics users should click on the paper and pencil icon to the left of the patient details when they appear on the Patient Search screen.

**Please note** that making this change creates a second version of the patient record. If it is a true change in circumstances since their last event e.g., change in surname, address, postcode or GP it is fine to make the change.

For other changes caused by incomplete information being available when the patient was created or a typing error occurring during data entry, the users must contact the SSCA generic mailbox (phs.strokeaudit@phs.scot) to ask for the central audit team to make the change so that a new version is not created.

### 1.72 Exiting from forms

Users should click on either the Save as Draft, Commit, Delete or Exit buttons at top/ bottom right of the screen to exit forms.

a) ***Save As Draft* button-** by selecting the *Save As Draft* button the user **will save the form but no validation is run.** Once the form is saved the user clicks the *Exit* button to exit the form and return to the previous page.

   **NB:** It is **recommended that the user saves the form to draft before committing the form.**

b) ***Commit* button -** by selecting the *Commit* button, **all validations will run**. To commit a form all fields require an entry unless they are 'greyed out' due to a preceding answer. Entry of *Not Recorded* or *Unknown* will allow the form to be committed.
   If the form is completed correctly the form is closed.
   If the form is not completed correctly the user is alerted to the necessary warning/ error messages:

   i. If **error messages** appear the form cannot be fully committed and is closed until the errors are addressed.

   ii. If only **warning messages** appear the user is given the following information *'Validation of this form is complete. There are however some warnings that you must confirm can be ignored. Click on OK to proceed to close this record or click Exit to review warnings. Once you have reviewed the warnings and want to close the form - press the Commit button and answer OK when prompted with this warning.'*

c) ***Delete* button -** by selecting the *Delete* button the user **will delete the form**. A warning message will appear - *'Would you like to perform this delete action?'* If the user selects *OK* the form will be deleted and the user returned to the previous page. If they select *Cancel* the user will be returned to the form.

d) ***Exit* button** - by selecting the *Exit* button the user will **exit the form without saving any changes**. A warning message will appear - *'If you have made any changes without saving or committing they will be lost. Click OK to exit this form or cancel to return without exiting.'* If the user selects *OK* they will exit the form without saving and return to the previous page.

### 1.73 Reopening an event on eSSCA

Users are unable to reopen an event once it has been committed. If there is a need to change/ update the data, the user should complete a data change request form and e-mail it to the SSCA generic mailbox (phs.strokeaudit@phs.scot) to have the event reopened.

## 2. Data Definitions

### 2.1 Notes

i. If you are unclear about any aspect of the proforma, data collection or the data definitions please do not hesitate to contact the central audit team, who will be happy to help you, by e-mailing the SSCA generic mailbox (phs.strokeaudit@phs.scot).

ii. All data entered into the Scottish Stroke Care Audit should be from information documented and evident in the patients' records (either paper or electronic). As a general rule, information provided anecdotally or through 'word of mouth' should not be included.

iii. The general categories '7s = Not recorded' and '8s = Unknown' can both mean slightly different things depending on what information is being collected, and this is further explained under each section below. Though '8s = unknown' may be used in some fields to indicate that the notes were not seen, **this should be avoided where possible. Every effort should be made to view the patient's records** in order to fully complete the audit and provide meaningful data.

iv. All dates should be entered using an eight-digit format i.e., DD/MM/YYYY e.g., 13/07/2021

v. All times should be entered using the 24-hour clock format i.e., HH:MM e.g., 15:10

vi. If 'other' option is used please remember to add additional relevant information to the free text field in the proforma where applicable.

| No. | Data item | Definition | Variable required |
|---|---|---|---|
| Demographics | Community Health Index (CHI) number | Record patient's unique Community Health Index (CHI) number, 10 digits.<br><br>**Notes:**<br>First six digits of the CHI are the patient's date of birth, i.e., DDMMYY. The ninth digit is always even for females and odd for males.<br><br>If you do not have a CHI, enter date of birth and four zeros.<br><br>If the patient's CHI is allocated later, this can be changed via the data change request process. | Enter a 10-digit number |
| Demographics | Date of birth | Record the date the patient was born or officially deemed to have been born as recorded on the Birth Certificate. | Enter an 8-digit number, i.e., DDMMYYYY |
| Demographics | Gender | Record the sex of the patient at birth. | Select one of the following:<br><br>Male<br>Female |

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| Demographics | Surname | Record the patient's surname.<br><br>eSSCA automatically capitalises the name | Enter surname – free text |
| Demographics | Forename | Record the patient's first name.<br><br>eSSCA automatically capitalises the name | Enter first name – free text |
| Demographics | Patient postcode | Record postcode for patient's normal residence at time of current cerebrovascular event.<br><br>**Notes:**<br>Use postcode for patient's normal residence if the patient is admitted from a home in which they are temporarily residing such as a holiday home or respite care.<br><br>Use the patient's home postcode if they have their stroke event whilst in acute or rehab ward. But if admitted from NHS continuing care use the hospital's postcode.<br><br>Use NK01 0AA for address not known.<br>Use NF1 1AB for no fixed abode.<br>Use 999X X for postcodes outside UK.<br>eSSCA automatically capitalises the letters. | Enter full postcode (up to 8 characters), e.g., EH54 9HT |
| Demographics | Ethnicity | Record the patient's ethnic origin – a statement made by the service user re their current ethnic group.<br><br>All health boards have a requirement to collect ethnicity data routinely.<br><br>**Notes:**<br>If ethnicity is not clearly documented in the patient's notes enter 'not known'. | Select patients ethnic group from the drop-down list:<br><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 |

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| | | | 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 |
| Demographics | GP practice | Record the patient's GP practice name/ address.<br><br>Select the GP practice from the GP Practice field in eSSCA by using key words or GP practice code if this is known. Click on the appropriate practice to populate the field.<br><br>**Notes:**<br>If the patient's GP is from out with Scotland, enter the GP's name and address in the text fields available.<br><br>Enter 'not known' if the patient's GP practice and/ or GP name is not known. | Select GP practice name from the drop-down list or if from out with Scotland, complete the text fields. |
| Demographics | GP name | Record the patient's GP name.<br><br>Select the GP's name from the prepopulated list. If the GP name is not on the list, select other and enter the GP name in the text field.<br><br>**Notes:**<br>You must select GP practice **before** selecting the GP name. | Select GP's name from the drop-down list or if from out with Scotland select other and complete the text field. |

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| Demographics | Other GP practice | If the patient's GP is from out with Scotland, enter the GP practice name and address. | Text field enter GP practice name and address |
| Demographics | Other GP | If the patient's GP is from out with Scotland, enter the GP name. | Text field enter the GPs name |
| **History** | | | |
| 1 | Date and time of arrival at first hospital | Record date and time of arrival at first hospital.<br><br>This is the hospital at which the patient first presents after a cerebrovascular event regardless of whether they are admitted or not.<br><br>This is the date/ time the patient arrived at the Emergency Department (ED) and **not** the date/ time the decision was made to admit the patient **or** the date/ time the patient was admitted to the ward.<br><br>For patients who do not attend ED but are directly admitted to a ward record, the date and time of arrival in the ward.<br><br>For patients who are already in hospital when they have their stroke record date and time of arrival at hospital for their original admission.<br><br>**Notes:**<br><br>Only use 7 (not recorded) if the notes were seen but no date or time is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>Enter time: HHMM<br><br>If date is not recorded then enter 07/07/0707<br>If the time is not recorded then enter 77:77<br><br>If the date is unknown then enter 08/08/0808<br>If the time is unknown then enter 88:88 |
| 2 | First hospital attended | Record the first hospital the patient presents to after a cerebrovascular event, regardless of whether they are admitted or not.<br><br>**Notes:**<br><br>Hospitals from the user's own health board should be at the top of the pick list in eSSCA.<br><br>Hospitals that are now inactive are prefixed with an * and included at the bottom of the pick list. | Select appropriate hospital from drop down pick list:<br><br>*Example Aberdeen Royal Infirmary* |

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| 3 | Admitting hospital | Record the hospital where the patient was admitted to for stroke care.<br><br>**Notes:**<br>Hospitals from the user's own health board should be at the top of the pick list on eSSCA.<br><br>Hospitals that are now inactive are prefixed with an * and included at the bottom of the pick list. | Select appropriate hospital from drop down pick list:<br><br>*Example: Aberdeen Royal Infirmary* |
| 4 | Date and time of arrival at admitting hospital | Record date and time of arrival at the admitting hospital.<br><br>This is the hospital at which the patient was admitted to for stroke care.<br><br>This is the date/ time of arrival at admitting hospital recorded in ED and **not** the date/ time decision was taken to admit the patient or when the patient was admitted to the ward.<br><br>For patients who do not attend ED but are directly admitted to a ward record the date and time of arrival in the ward.<br><br>For patients who are already in hospital when they have their stroke record date and time of admission to hospital for their original admission.<br><br>*NB: this field will be automatically populated in eSSCA if the admitting hospital entered is the same as the arrival hospital.*<br><br>**Notes:**<br><br>Only use 7 (not recorded) if the notes were seen but no date or time is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>Enter time: HHMM<br><br>If date is not recorded then enter 07/07/0707<br>If the time is not recorded then enter 77:77<br><br>If the date is unknown then enter 08/08/0808<br>If the time is unknown then enter 88:88 |
| 5 | Where was the patient admitted from? | Record the current residence of the patient prior to cerebrovascular event:<br><br>**Home/ sheltered** = when the patient is living at their normal residence, i.e., permanent address or if they are permanently living with a relative. Also use this option if the patient has cerebrovascular event whilst on holiday or working away from home.<br><br>**Care home** = this can be a residential or nursing home provided it is the person's permanent home. | Select one of the following in line with the descriptions opposite:<br><br>Home/ sheltered<br>Care home<br>NHS continuing care<br>Rehabilitation<br>Acute hospital<br>Other<br>Not recorded |

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| | | **NHS continuing care** = when the patient has cerebrovascular event in a ward where the clinical team is no longer attempting to get a patient home. The patient may be awaiting a place in a nursing home or for funding, or may have become a permanent hospital patient, i.e., now in a long-term care bed. Before allocating this code, always check with the nurse in charge of the patient's care to determine the exact reasoning for the patient's placement.<br><br>Include long-term elderly psychiatry as NHS continuing care.<br><br>**Rehabilitation** = when the patient has cerebrovascular event in a dedicated rehabilitation ward or a bed in a ward where rehabilitation occurs.<br><br>**Acute hospital** = when the patient has cerebrovascular event in an acute hospital ward. Include acute psychiatry wards as acute hospital.<br><br>**Other** = includes intermediate care, non-NHS respite care or hospice, prison, homeless or private hospital care.<br><br>**Notes:**<br><br>Only use not recorded if the notes were seen but no record of where patient was admitted from.<br><br>Only use unknown if the notes were not seen. | Unknown |
| 6 | Source of referral to first hospital | Record the original source of referral to first arrival hospital.<br><br>**999** = patient transferred to ED by ambulance initiated by a member of the public. This includes the patient contacting 999 directly.<br><br>**GP** = patient attends/ transferred to ED by any means initiated by GP.<br><br>**NHS24** = patient attends/ transferred to ED by any means that was initiated by NHS24.<br><br>**Other Out of Hours** = patient attends/ transferred to ED by means that was initiated by NHS24.<br><br>**Self** = only use for patients who self-present at ED (this includes MIU). | Select one of the following in line with the descriptions opposite:<br><br>999<br>GP<br>NHS24<br>Other Out of Hours<br>Self<br>This hospital<br>Other hospital<br>Other<br>Not recorded<br>Unknown |

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| | | **This hospital** = patients who have their stroke whilst an inpatient in your hospital.<br><br>**Other hospital** = patient transferred to admitting hospital from a different acute hospital e.g. had a stroke whilst inpatient in another hospital then transferred to your hospital for stroke care.<br><br>**Other** = only use other if none of the above codes are relevant.<br><br>**Notes:**<br>Only use not recorded if the notes were seen but no record of source of referral.<br><br>Only use unknown if the notes were not seen. | |
| 7 a-c | Consultant responsible for hyperacute/ acute stroke care | Record the consultant under whose care the patient was at the time of **discharge** from acute stroke care.<br><br>**Notes:**<br>If the patient is admitted to more than one hospital or stroke unit and has a different consultant, this information can be collected in 7b and 7c.<br><br>List of consultants is managed by the SSCA central audit team. The pick list will be 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>Please contact the SSCA mailbox if you require a consultant to be added or taken off this list (see Appendix B)<br><br>Pick list includes options of GP, Not Applicable and Other. | Select responsible consultant from drop down pick list, or<br><br>GP<br>Not applicable<br>Other |
| 8 | Did the patient wake from sleep with the symptoms of stroke or TIA? | Record whether or not the patient woke from sleep with the symptoms of stroke or TIA relating to current event.<br><br>**Notes:**<br>Only use not recorded if the notes were seen but no record of whether or not the patient woke from sleep with the symptoms of stroke or TIA.<br><br>Only use unknown if the notes were not seen or if it is documented in the patient's notes that it was not known if the patient woke from sleep with the symptoms of stroke or TIA. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |

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| 9 | Is time of onset of symptoms known to within 15 minutes? | Record whether the time of onset of symptoms relating to the current event is known to within 15 minutes.<br>**Notes:**<br>Only use not recorded if the notes were seen but no record of whether time of onset of symptoms is known to within 15 minutes.<br><br>Only use unknown if the notes were not seen or if it is documented that the time of onset of symptoms is unknown to within 15 minutes. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |
| 10 | Date/ time of onset of symptoms relating to current event | Record date and time of onset of the patient's first focal cerebral symptoms relating to current event.<br><br>**Date**<br>This date is necessary to complete the form.<br><br>**Time**<br>If the stroke is <u>witnessed</u> the precise time of stroke should be entered.<br><br>**Notes:**<br>For patients who arrive at hospital following a cerebrovascular event, if the patient woke from sleep, then the precise time of stroke may be unknown. However, if known, the time the patient went to sleep should be recorded. This is important as if for example the patient went to sleep only 2 hours ago and woke with a stroke, they could potentially still meet the criteria for thrombolysis treatment.<br><br>For patients who have a cerebrovascular event whilst an inpatient, record the date and time when the patient first complains of feeling unwell or is first seen unwell with symptoms of a stroke or TIA.<br><br>This information should be found within the patient's healthcare record.<br><br>*NB: If the date and time of onset is after the date of admission, i.e., when patient already in hospital has a stroke, the date and time in this data field will be used when calculating times to admission to stroke unit, computerised tomography (CT) scan, swallow screen and aspirin prescription.*<br><br>Only use 7 (not recorded) if the notes were seen but no record of date/ time of onset of symptoms relating to current event is documented. | Enter date: DDMMYYYY<br><br>Enter time: HHMM<br><br>If date is not recorded then enter 07/07/0707<br>If the time is not recorded then enter 77:77<br><br>If the date is unknown then enter 08/08/0808<br>If the time is unknown then enter 88:88 |

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| | | Only use 8 (unknown) if the notes were not seen or it is documented in the notes that date/ time of onset of symptoms relating to current event is unknown. | |
| 11 | Was thrombolysis given or clot retrieval performed? | Record whether thrombolysis was performed. If yes, complete thrombolysis data collection form in addition to the inpatient form.<br><br>For patients who only have clot retrieval performed, answer no.<br><br>**Notes:**<br>Actilyse, Alteplase or Tenecteplase will usually appear on the drug chart in the once only or infusion section.<br><br>eSSCA will not allow you to commit an inpatient form if this question is answered 'yes' and there is no thrombolysis form.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 12 | Does the patient have a past medical history of Atrial Fibrillation/ Atrial Flutter (AF)? | Record whether the patient has a clear past medical history of Atrial Fibrillation or Atrial Flutter (AF) (either permanent or temporary) documented in their records (at any time).<br><br>**Notes:**<br><br>Only use unknown if the notes were not seen. | Enter:<br>Yes<br>No<br>Unknown |
| 13 | 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><br>Warfarin<br>Rivaroxaban<br>Apixaban<br>Treatment dose heparin > 15000 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><br>Record no if on:<br>Standard heparin ≤ 15000 units/day<br>Enoxaparin (LMWH) ≤ 40 units/ day<br>Tinzaparin (LMWH) ≤ 5000 units/ day | Enter:<br><br>Yes<br>No<br>Unknown |

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| | | Dalteparin (LMWH) ≤ 5000 units/ day<br>Berniparin (LMWH) ≤ 5000 units/ day<br>Fondaparininux (LMWH) ≤ 2.5mhs/ day<br><br>**Notes:**<br>Record yes if the patient was involved in a relevant clinical trial of anticoagulants.<br><br>Anticoagulation does NOT include Aspirin, Clopidogrel, Ticagrelor, Prasugrel or Dipyridamole.<br><br>Only use unknown if the notes were not seen. | |
| 14 | Was stroke the most likely or significant early diagnosis made in hospital? | Record yes when the diagnosis of stroke was the most likely early diagnosis made in hospital.<br><br>This will be after the first assessment of the patient and usually prior to admission.<br><br>Further information on inpatient admission is available here:<br>https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=I&ID=299&Title=Inpatient%20Admission<br><br>**Notes:**<br>You should not include patients where a stroke specialist (someone with a special interest in stroke or responsible for stroke care in that hospital) on their initial clinical assessment rejects a diagnosis of stroke.<br><br>If the date and time of onset is after the date of admission i.e., when a patient already in hospital has a stroke, the initial diagnosis refers to the stroke event.<br><br>Please refer to the Flow Chart for Inclusion in SSCA for further guidance – Appendix A | Enter:<br><br>Yes<br>No<br>Unknown |
| 15 | Was TIA the most likely or significant early diagnosis made in hospital? | Record yes when the diagnosis of TIA was the most likely early diagnosis made in hospital.<br><br>This will be after the first assessment of the patient and usually prior to admission.<br><br>Further information on inpatient admission is available here:<br>https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=I&ID=299&Title=Inpatient%20Admission | Enter:<br><br>Yes<br>No<br>Unknown |

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| | | **Notes:**<br><br>You should not include patients where a stroke specialist (someone with a special interest in stroke or responsible for stroke care in that hospital) on their initial clinical assessment rejects a diagnosis of TIA.<br><br>If the date and time of onset is after the date of admission i.e., when a patient already in hospital has a TIA, the initial diagnosis refers to the TIA event.<br><br>Please refer to the Flow Chart for Inclusion in SSCA for further guidance – Appendix A | |
| Questions 16-21 relate to case mix.<br>**NB:** when completing case mix fields, the exact wording may not appear in the notes. These questions are crucial for when the dataset is linked to other datasets for research purposes. It is acceptable to collect current case mix adjustors by interpreting other information in the patients notes i.e. reading between the lines. | | | |
| 16 | Was the patient independent in Activities of Daily Living (ADL) before the current event? | Record whether the patient was independent in Activities of Daily Living (ADL) **prior to the current event.**<br><br>**Notes:**<br>Record yes if the patient is independent in activities related to self-care that allows them to look after themselves in their given environment i.e., walking (at least around their house), washing, dressing, feeding (not meal preparation) and toileting.<br><br>Only use not recorded if the notes were seen but no record of whether the patient was independent of ADL prior to the current event is noted.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |
| 17 | In their normal place of residence did the patient live alone? | Record if the patient lived alone in their normal place of residence.<br><br>**Notes:**<br>If they are living away from their normal place of residence temporarily - e.g., on holiday or in hospital - please be sure to enter information relating to their **normal** permanent place of residence, not their temporary place of residence. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |

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| | | If the patient is living in a residential or nursing home, they **should NOT be coded as living alone**. If they live alone in a warden-controlled apartment, then this should be coded as living alone.<br><br>Only use not recorded if the notes were seen but no record of whether the patient lives alone in their normal residence is noted.<br><br>Only use unknown if the notes were not seen. | |
| 18 | Can the patient talk at first assessment? | This data item should be taken from the **first hospital assessment** following onset of symptoms of current event. This assessment can be by any member of the healthcare team.<br><br>**Notes:**<br>Record yes if it is noted that the patient is able to talk at first assessment.<br><br>Record no if the patient's speech is unable to be assessed for any reason or the patient cannot communicate verbally.<br><br>They may have difficulties in doing this, they may lack fluency. This question combined with the one below relating to orientated in time, place and person would be used to define whether Glasgow Coma Scale (GCS) Verbal is 5 or less.<br>If cannot talk then <5<br>If can talk but not orientated <5<br>If can talk and orientated = 5<br><br>Only use not recorded if the notes were seen but no record if the patient can talk at first assessment is noted.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |
| 19 | Is the patient orientated to time, place and person at first assessment? | This data item should be taken from the **first hospital assessment** following onset of symptoms of current event. This assessment can be by any member of the healthcare team.<br><br>**Notes:**<br>Can the patient tell you their name, the place and time correctly – yes or no.<br><br>The question is based on the verbal component of the Glasgow Coma Scale (GCS), where:<br>5 = orientated<br>4 = confused<br>3 = inappropriate words | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |

| | | | |
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| | | 2 = groans<br>1 = none<br><br>If 5, record as yes (orientated), otherwise record as no (including patients who are unassessable for any reason).<br>If recorded as confused or abbreviated mental test score of <8 record no.<br><br>Only use not recorded if the notes were seen but no record if patient is orientated to time, place and person at first assessment is noted.<br><br>Only use unknown if the notes were not seen. | |
| 20 | Can the patient lift both arms off the bed at first assessment? | This data item should be taken from the **first hospital assessment** following onset of symptoms of current event, this assessment can be by any member of the healthcare team.<br><br>**Notes:**<br>We do not stipulate that they should be able to keep their arms off the bed for any specific period or lift them to keep them horizontal.<br><br>Should the unaffected arm be completely missing, code the affected arm only. Should the affected arm be missing, code on the affected leg instead, if possible, otherwise code as no.<br>If Medical Research Council (MRC) Arm Power is recorded as ≤2/5, severe weakness, paralysed or flaccid on either side, record no (abnormal).<br><br>Only use not recorded if the notes were seen but no record of whether the patient can lift both arms off the bed at first assessment.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |
| 21 | Is the patient able to walk without help from another person? | Record yes if the patient is able to walk without the help of another person. They may use another aid e.g. walking stick or frame.<br><br>**Notes:**<br>This data item should be taken from the **first record of mobility up to and including the first assessment by a physiotherapist.**<br><br>Only use not recorded if the notes were seen but no record of mobility was recorded up to and including the first assessment by a physiotherapist.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |

| Investigations | | | |
|---|---|---|---|
| 22 | Has brain imaging been done since current event? | Record if brain imaging (CT or magnetic resonance imaging (MRI) scan) has been done since current cerebrovascular event.<br><br>**Notes:**<br>Only use unknown if the notes were not seen. | Enter:<br>Yes<br>No<br>Unknown |
| 23 | **Date and time of first brain imaging for current event** | Record the date and time of first brain imaging for current cerebrovascular event.<br><br>**Notes:**<br>It is important to **record the actual time the scan was carried out** and not the time it was requested or reported.<br><br>Only use 7 (not recorded) if the notes were seen but no record of date/ time of brain imaging for current event.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>Enter time: HHMM<br><br>If date is not recorded then enter 07/07/0707<br>If the time is not recorded then enter 77:77<br><br>If the date is unknown then enter 08/08/0808<br>If the time is unknown then enter 88:88 |
| 24 | Where was the **first** brain imaging for current event performed? | Record the name of the hospital where first brain imaging for current event was performed. | Select appropriate hospital from drop down pick list:<br><br>*Example: Aberdeen Royal Infirmary* |
| 25 | Did the brain imaging results clearly indicate <u>only a non- stroke diagnosis</u>? | Record yes if the brain imaging indicated only a non-stroke diagnosis e.g., malignancy, tumour<br><br>**Notes:**<br>If yes, remove the patient from the audit at this point by entering a discharge from stroke care date (question 53) i.e. date of scan or date scan was read.<br><br>There is no need to complete any further audit information however in order to commit the record in eSSCA, you will need to enter unknown for the remaining fields.<br><br>Any uncertainty on removing a patient from the audit, contact the stroke mailbox for advice phs.strokeaudit@phs.scot | Enter:<br><br>Yes<br>No<br>Unknown |

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| | | An auditor's role does not include interpreting scans/ reports.<br><br>Please look for clear records of diagnostic decisions in the notes and take advice from your clinical team where there might be ambiguity.<br><br>Only use unknown if the notes were not seen. | |
| 26 | Has imaging of Internal Carotid Artery (ICA) been performed since current event? | Record yes if Internal Carotid Artery (ICA) imaging has been performed since current cerebrovascular event and at any point during the current hospital inpatient stay.<br><br>**Notes:**<br>Examples of ICA imaging are:<br><br>Carotid doppler<br>Ultrasound<br>Duplex<br>CT angiogram (CTA)<br>MR angiogram (MRA)<br>Intra-arterial angiography<br>CT Venogram<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 27 | Date of 1st imaging of ICA for current event | Record date of first imaging of ICA for current cerebrovascular event.<br><br>**Notes:**<br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br><br>If the date is unknown then enter 08/08/0808 |
| 28 | Where was the **first** imaging of ICA for current event performed? | Record the name of the hospital where first imaging of ICA for current event was performed. | Select appropriate hospital from drop down pick list:<br><br>*Example: Aberdeen Royal Infirmary* |
| 29 | Was AF confirmed during current hospital inpatient stay? | Record yes if AF was demonstrated on electrocardiograph (ECG) (or 24-hour tape or echocardiogram) at any point during the current hospital inpatient stay.<br><br>**Notes:**<br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |

| **Diagnosis** | | | |
|---|---|---|---|
| 30 | Did the final diagnosis include stroke? | 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).<br><br>Record no if the stroke diagnosis is possible (meaning there is at least one alternative which is more likely than stroke).<br><br>**Notes:**<br>The final diagnosis may be taken from the patient's notes, discharge or transfer letter at the time of discharge from active stroke care.<br><br>Only use not recorded if the notes were seen but no final diagnosis is recorded.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |
| 31 | Did the final diagnosis include TIA? | 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).<br><br>Record no if the TIA diagnosis is possible (meaning there is at least one alternative which is more likely than TIA). This will include for example transient monocular blindness or amaurosis fugax (AFx) which are TIAs of the eye.<br><br>**Notes:**<br>The final diagnosis may be taken from the patient's notes, discharge or transfer letter at the time of discharge from active stroke care.<br><br>Only use not recorded if the notes were seen but no final diagnosis is recorded.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Not recorded<br>Unknown |
| 32 | Stroke pathology | Record the pathology of the **index stroke event**.<br><br>**Notes:**<br>The index stroke event relates to the initial stroke which has led to inclusion in the audit.<br><br>Only use uncertain if it is clearly written in the notes that the pathology of the stroke is uncertain. | Select stroke pathology from the drop-down pick list:<br><br>Ischaemic<br>Haemorrhagic<br>Haemorrhagic transformation of infarct<br>Uncertain<br>Not recorded |

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| | | Only use not recorded if there is no record of the stroke pathology or notes were not seen. | |
| **Acute Management** | | | |
| 33a-c | Was the patient managed in an Acute/ Integrated Stroke Unit? | This includes hyperacute stroke units, acute stroke units and integrated stroke units. See **Appendix C** for definitions of stroke units. Multidisciplinary team meetings should take place at least weekly and the staff will have received specific training in stroke (minimum of STARS 1 training).<br><br>**Notes:**<br>This would not include patients who are cared for in other beds even if looked after by members of a stroke multidisciplinary team.<br><br>If the patient is admitted to more than one acute/ integrated stroke unit this information can be collected in the additional fields provided (33b&c to 36b&c).<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 34a-c | Acute/ Integrated Stroke Unit | Record the name of the hospital where the acute/ integrated stroke unit is situated. | Select appropriate hospital from drop down pick list:<br><br>*Example: Aberdeen Royal Infirmary* |
| 35a-c | **Date of entry to Acute/ Integrated Stroke Unit** | Record the date the patient was admitted to the acute/ integrated stroke unit.<br><br>**Notes:**<br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br><br>If the date is unknown then enter 08/08/0808 |
| 36a-c | Date of exit from Acute/ Integrated Stroke Unit | Record the date the patient was discharged from the acute/ integrated stroke unit. This can be to any destination e.g., home/ another ward/ unit/ hospital.<br><br>**Notes:**<br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br><br>If the date is unknown then enter 08/08/0808 |

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| 37 | Was swallow screen recorded for current event? | Record yes if there is a clear record of swallow screen assessment being carried out for current event. This does not need to include a water swallow test as this may not always be appropriate in situations where it may be hazardous to the patient.<br><br>**Notes:**<br><br>Record yes if there is a clear record of low conscious level e.g., GCS <9 or if the patient is unable to sit up without support, or the patient has been intubated.<br><br>Record yes if it is documented that a patient is Nil by Mouth as being considered for thrombectomy or any other surgical procedure.<br><br>Record no if patient is routine Nil by Mouth without a documented reason.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 38 | **Date and time of first swallow screen for current event** | Record the date and time the swallow screen was performed for the current event.<br><br>**Notes:**<br><br>If there is a clear record of low conscious level e.g., GCS <9 or if the patient is unable to sit up without support, or the patient has been intubated, record the date and time that this has been documented in the patients notes. If documented by the Scottish Ambulance Service (SAS), use the date and time of arrival at first hospital.<br><br>Only use 7 (not recorded) if the notes were seen but no date/ time of swallow screen relating to current event is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>Enter time: HHMM<br><br>If date is not recorded then enter 07/07/0707<br>If the time is not recorded then enter 77:77<br><br>If the date is unknown then enter 08/08/0808<br>If the time is unknown then enter 88:88 |
| 39 | Where was the **first** swallow screen for current event performed? | Record the name of the hospital where the first swallow screen for the current event was performed. | Select appropriate hospital from drop down pick list:<br><br>*Example: Aberdeen Royal Infirmary* |

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| 40 | Was aspirin given in hospital? | Record yes if aspirin was given in hospital following onset of symptoms.<br><br>**Notes:**<br>Only use yes if there is clearly documented evidence that aspirin has been given and not just prescribed. This can be a stat dose or regular dose of aspirin.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 41 | **Date of first dose of aspirin for current event** | Record the date aspirin was first given in hospital following onset of symptoms.<br><br>**Notes:**<br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date:<br>DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br><br>If the date is unknown then enter 08/08/0808 |
| 42 | Where was the **first** dose of aspirin given for current event? | Record the name of the hospital where the first dose of aspirin for the current event is given. | Select appropriate hospital from drop down pick list:<br><br>*Example:*<br>*Aberdeen Royal Infirmary* |
| 43 | **Why was aspirin not given?** | Record the reason why aspirin was not given.<br><br>**Notes:**<br>This question will only be available to answer if you have answered no to the question 'Was aspirin given in hospital'.<br><br>Only use not recorded if the notes were seen but no record of reason why aspirin was not given is documented.<br><br>Only use unknown if the notes were not seen. | Select reason from the drop-down list:<br><br>Died before scan<br>Died while aspirin embargoed due to other medical condition or treatment<br>Haemorrhagic stroke (current diagnosis or past medical history)<br>Haemophilia or bleeding disorder<br>On Warfarin or Heparin<br>On other oral anticoagulant<br>Recent gastrointestinal (GI) bleed<br>Active peptic ulcer<br>Known allergy |

| | | | |
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| | | | Breast feeding<br>Patient refused<br>Other (not valid CI)<br>On 'end of life pathway'<br>Patient already taking an alternative antiplatelet at time of admission<br>Significant haemorrhagic transformation of infarction (including post thrombolysis)<br>Patient involved in research trial<br>Unknown<br>Not recorded |
| 44 | Was alternative antiplatelet given in hospital? | Record yes if an alternative antiplatelet was given in hospital following current cerebrovascular event e.g., clopidogrel, dipyridamole or if in a clinical trial of antiplatelet drug(s), as applicable.<br><br>**Notes:**<br>Only use yes if there is clearly documented evidence that alternative antiplatelet has been given and not just prescribed.<br><br>This question will only be available to answer if you have answered no to the question, 'was aspirin given in hospital?'.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 45 | Date of first dose of alternative antiplatelet given in hospital | Record the date alternative antiplatelet was given in hospital.<br><br>**Notes:**<br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date: DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br>If the date is unknown then enter 08/08/0808 |
| 46 | Where was the **first** dose of alternative antiplatelet given for current event? | Record the name of the hospital where the first dose of alternative antiplatelet for the current event is given. | Select appropriate hospital from drop down pick list:<br><br>*Example: Aberdeen Royal Infirmary* |

| Further specialist management | | | |
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| 47a-c | Was the patient managed in a Stroke Rehabilitation Unit (SRU)? | Record yes if the patient was managed in a Stroke Rehabilitation Unit (SRU).<br><br>**Notes:**<br>Only answer yes if the patient is cared for in a separate, defined SRU.<br><br>Record no if the patient is managed in an Integrated Stroke Unit that has rehabilitation functions.<br><br>A SRU is a ward or part of a ward which is designated specifically for the rehabilitation of patients with stroke. Multidisciplinary team meetings should take place at least weekly and the staff will have received specific training in stroke (minimum of STARS1 training)<br><br>If the patient is admitted to more than one SRU, this information can be collected in the additional fields provided.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 48a-c | Hospital where SRU situated | Record the name of the hospital where the SRU is situated.<br><br>Hospitals from the user's health board should be at the top of the list.<br><br>Hospitals that are now inactive are prefixed with an * and included at the bottom of the list. | Select appropriate hospital from drop down pick list:<br>*Example: Aberdeen Royal Infirmary* |
| 49a-c | Date of entry to SRU | Record the date of entry to the SRU.<br><br>**Notes:**<br>This can be from any source e.g., acute stroke unit, other ward/ unit/ hospital.<br><br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | Enter date:<br>DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br><br>If the date is unknown then enter 08/08/0808 |
| 50a-c | Date of exit from SRU | Record the date when the patient was discharged from the SRU.<br><br>**Notes:**<br>This can be to any destination e.g., home, another ward/ unit/ hospital. | Enter date:<br>DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707 |

| | | | |
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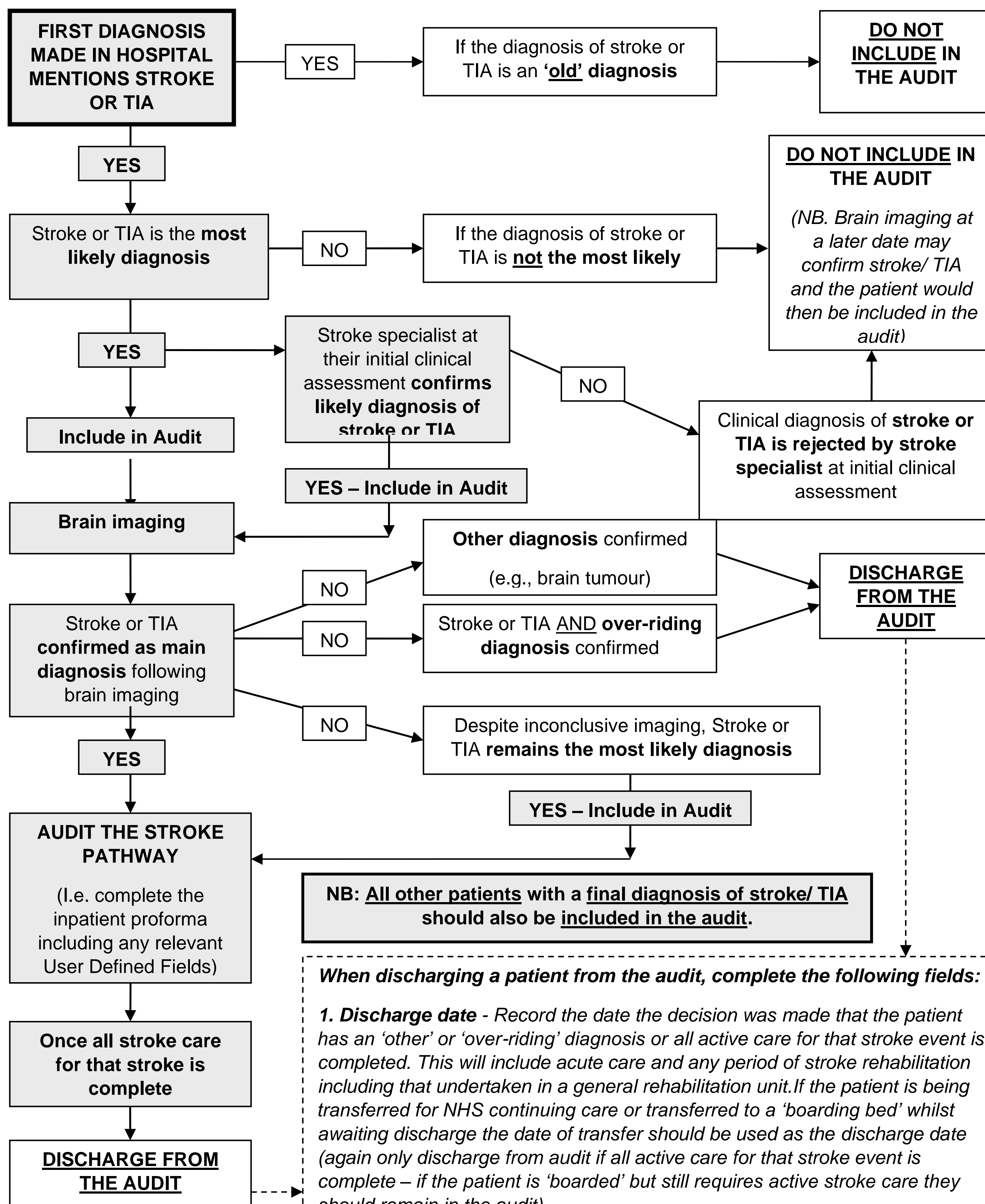
| | | Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen. | If the date is unknown then enter 08/08/0808 |
| 51a-c | Responsible consultant for stroke rehabilitation | Record the consultant under whose care the patient was at the time of **discharge** from stroke rehabilitation.<br><br>**Notes:**<br>If the patient is admitted to more than one hospital or rehabilitation unit and has a different consultant, this information can be collected in 51b and 51c.<br><br>List of consultants is managed by the SSCA central audit team. The list will be sorted by health board with the user's health board at the top of the list.<br><br>Retired/ inactive consultants names are prefixed with an * and included at the bottom of the list.<br><br>Please contact the SSCA mailbox (phs.strokeaudit@phs.scot) if you require a consultant to be added or taken off this list (see Appendix B)<br><br>The list includes options of GP, not applicable and other. | Select responsible consultant from drop down pick list or:<br><br>GP<br>Not applicable<br>Other |
| **Patient Pathway** | | | |
| 52 | Discharged to | Record the place that the patient was discharged to from stroke care.<br><br>**Home/sheltered** = when the patient is discharged home, i.e., permanent address or if they are permanently living with a relative. This should include when the patient is discharged home with support from the Hospital at Home team.<br><br>**Care home** = this can be a residential or nursing home provided it is the person's permanent home/ usual place of residence.<br><br>**NHS continuing care** = when the clinical team is no longer attempting to get a patient home. The patient may be awaiting a place in a nursing home or for funding, or may have become a permanent hospital patient, i.e., now in a long-term care bed. Before allocating this code, always check with the nurse in charge of the | Select one of the following in line with the descriptions opposite:<br><br>Home/ sheltered<br>Care home<br>NHS continuing care<br>Rehabilitation<br>Acute hospital<br>Died<br>Other<br>Not recorded<br>Unknown |

<table>
<tr><td></td><td></td><td>patient's care to determine the exact reasoning for the patient's placement.<br><br>Include long-term elderly psychiatry as NHS continuing care.<br><br>Rehabilitation = when the patient is transferred to a dedicated rehabilitation ward or a bed in a ward where rehabilitation occurs.<br><br>Acute hospital = when the patient is discharged to another acute ward such as general medicine, critical care, acute psychiatry or care of the elderly.<br><br>Died = the person died prior to leaving stroke care.<br><br>Other = includes intermediate care, non-NHS respite care or hospice, prison, homeless or private hospital care.<br><br>Notes:<br>Only use not recorded if the notes were seen but no record of where the patient was discharged to.<br><br>Only use unknown if the notes were not seen.<br><br>If a patient discharges themselves against medical advice, please record where they are discharged to.</td><td></td></tr>
<tr><td>53</td><td>Discharge date from 'stroke care'</td><td>Record the date of discharge from stroke care.<br><br>Notes:<br><br>The discharge date is the date at the end of all care for the cerebrovascular event including acute care and any period of stroke rehabilitation including that undertaken in a general rehabilitation unit.<br><br>If the patient was transferred to an acute, NHS continuing care ward or a boarding bed prior to discharge from hospital, use the date of transfer from the stroke ward/ stroke rehabilitation ward to the other ward as the date of discharge.<br><br>Only use 7 (not recorded) if the notes were seen but no date is recorded.<br><br>Only use 8 (unknown) if the notes were not seen.</td><td>Enter date: DDMMYYYY<br><br>If date is not recorded then enter 07/07/0707<br><br>If the date is unknown then enter 08/08/0808</td></tr>
</table>

| 54 | Was anticoagulation prescribed or recommended at discharge | Record yes if anticoagulation was prescribed or recommended at discharge:<br><br>Warfarin<br>Rivaroxaban<br>Apixaban<br>Treatment dose heparin > 15000 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 (Pradaxal)<br><br>**Notes:**<br>Record yes if the patient was involved in a relevant clinical trial of anticoagulants.<br><br>Anticoagulation does NOT include Aspirin, Clopidogrel or Dipyridamole.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
|---|---|---|---|
| 55 | Was the patient referred for a carotid intervention? | Record whether the patient was referred for a carotid intervention during their admission for this cerebrovascular event.<br><br>**Notes:**<br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |
| 56 | Did the patient have a carotid intervention? | Record whether the patient has had a carotid intervention_**relating to this cerebrovascular event.**<br><br>If yes, complete carotid intervention data collection form in addition to the inpatient form.<br><br>**Notes:**<br>eSSCA will not allow you to commit an inpatient form if this question is answered ‘yes’ and there is no carotid intervention form.<br><br>Only use not recorded if the notes were seen and you have answered yes to Q55 but there is nothing in notes confirming whether patient had a carotid intervention or not.<br><br>Only use unknown if the notes were not seen. | Enter:<br><br>Yes<br>No<br>Unknown |

# Appendix A Inpatient Flow Chart demonstrating inclusion in SSCA



## Appendix B Maintaining consultant lists within eSSCA

The consultant lists within eSSCA are managed by the SSCA central audit team however it is the responsibility of every health board to ensure that the lists are up to date.

When a new consultant joins your team, contact the SSCA central audit team via the SSCA mailbox – phs.strokeaudit@phs.scot to ask for them to be added to the consultant list.

Ensure you include the full name of the doctor/ surgeon, their GMC number and their hospital base in your e-mail request. Colleagues in local health boards or the person you are requesting to be added to eSSCA should be able to give you this information.

Alternatively you can look them up on the GMC website - The medical register - GMC (gmc-uk.org)

Also confirm if they are a vascular surgeon so they will appear on the carotid intervention form.

Inactive consultants will still appear on eSSCA but will be at the bottom of the list with an * preceding their name. This is because there will be data on the system relating to this consultant. It also means that if data are entered retrospectively an inactive consultant can still be chosen from the list.

## Appendix C Definitions of stroke units

| Stroke unit model | 'Typical' timings | | 'Typical' route of admission | Objectives |
|---|---|---|---|---|
| | Admission | Discharge | | |
| Hyperacute | <6 hrs | Usually 1–2 days | Direct from the Emergency Department | Provides specialist medical and nursing care during the hyperacute period when revascularisation (spontaneous or interventional) might occur.<br><br>Monitoring and intervention focus on physiological variables and early complications |
| Acute | <24 hrs | Usually several days | From hyperacute unit or medical admissions unit | Provides stroke unit care in the first few days after stroke; including assessment, investigation and intervention (but usually beyond the time window for revascularisation).<br><br>Monitoring and intervention focus on physiological variables and early complications. Provides appropriate early rehabilitation activities in patients with acute medical problems. |
| Rehabilitation | Days–weeks | Weeks | From acute or integrated unit | Provides stroke unit care, with an emphasis on rehabilitation, but not involved in acute medical care. Usually begins several days after stroke onset and continues rehabilitation for several weeks to months as required. |
| Integrated | <24 hrs | Days-weeks | From hyperacute unit or medical admissions unit | Combines both acute and rehabilitation phases in one unit.<br><br>Overlap of characteristics with "acute" above. |