## Portsmouth Hospitals

NHS Trust

# ACUTE STROKE PATHWAY DOCUMENT

### Stroke is defined as:

A clinical syndrome of presumed vascular origin, typified by rapidly developing signs of focal or global disturbance of cerebral function lasting more than 24 hours or leading to death.

### TIA is defined as:

A resolved neurovascular episode in which an acute loss of cerebral or ocular function occurs with symptoms lasting less than 24 hours.

## Addressogram/Patient details

Ward/Unit	Patient Transfer Histo Date	Time	Comment
	Date	Time	oonment
Admission			
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<u>STROKE IS A MEDICAL EMERGENCY</u> TAKE URGENT ACTION IF PATIENT PRESENTS WITHIN 3 HOURS OF ONSET OF NEUROLOGICAL DEFICITS (see separate thrombolysis guideline)

Please also refer to National Clinical Guidelines for Stroke (2008) available at www.rcplondon.ac.uk, National Institute for Health and Clinical Excellence guidance available at www.nice.org.uk and local stroke guidelines

Name:

**Hospital Number:** 

Aguta Stroke Pathway, signature record

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#### Stroke

A clinical syndrome of presumed vascular origin, typified by rapidly developing signs of focal or global disturbance of cerebral function lasting more than 24 hours or leading to death.

#### **Transient Ischaemic Attack TIA**

A resolved neurovascular episode in which an acute loss of cerebral or ocular function occurs with symptoms lasting less than 24 hours.

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#### 3 Stroke Types

Ischaemic Stroke Primary Intracerebral Haemorrhage Subarachnoid Haemorrhage

#### Clinical sub-groups of cerebral infarction (adapted from Oxford Community Stroke Project) Total Anterior Circulation Infarction (TACI)

All 3 of:

a) Dense hemiplegia

b) Homonymous hemianopia

c) Higher cerebral function disturbance i.e. dysphasia, visuospatial disturbance, agnosia

Partial Anterior Circulation Infarction (PACI)

Any 2 of the above, isolated monoparesis or higher cerebral function disturbance as in c) above

#### Posterior Circulation Infarction (POCI)

Cranial nerve palsies with opposite side sensory and/or motor deficits Bilateral simultaneous sensory and/or motor loss Dysconjugate eye movements Cerebellar dysfunction without ipsilateral weakness Isolated hemianopia or cortical blindness

Lacunar Infarction (LACI) Pure motor stroke Pure sensory stroke Sensory/motor stroke Ataxic hemiparesis - ataxia same side as weakness NOTE: no hemianopia, no cortical deficit with at least two out of arm, leg or face involved and with the whole limb involved.

#### National Institutes of Health Stroke Scale NIHSS

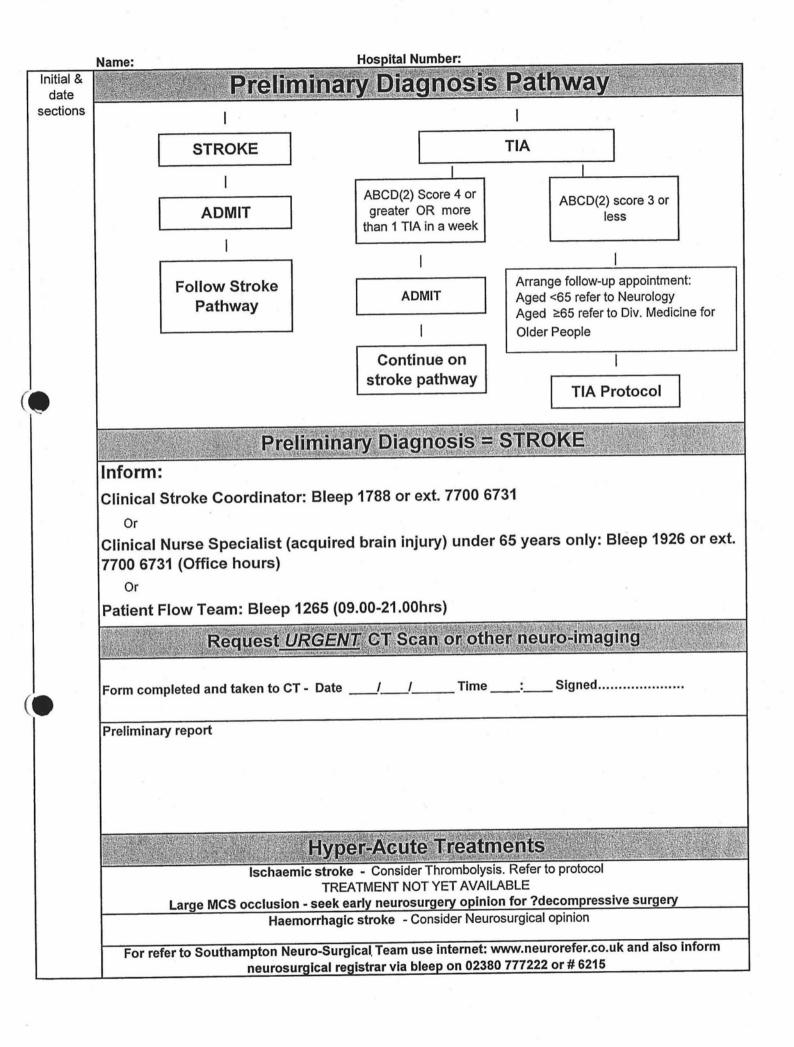
A scale that must used with patients receiving thrombolysis. Requires on line training available at: http://www.professionaleducationcenter.americanheart.org and select NIH stroke scale course link. Also available via Portsmouth Hospitals NHS Trust learning and Development zone.

MRC Power Scale	
MRC Grade 5	No weakness
MRC Grade 4	Movement against resistance but weaker than the other side
MRC Grade 3	Movement against gravity but not against resistance
MRC Grade 2	Movement only with gravity eliminated
MRC Grade 1	Palpable contraction but no visible movement
MRC Grade 0	No movement
Please note the MRC	Socale was devised to record power on a background of normal tone. Please also

note tone/spasticity in all limbs when using the MRC power scale.

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	<u>A</u> rm	Arm Can the person raise both arms, hold them at 90 degrees when sitting (45 degrees if lying) with their eyes shut for 5 seconds? If one arm has weakness this will drift downwards compared to the unaffected limb.								
	<u>S</u> peech	8	rson speak to you by to them? Is their spee		nd understa	and what is				
	<u>T</u> est	All three symptoms – if at least one out of three demonstrate a deficit, the suspect a stroke.								
			Consider these	points		Y	N			
	Did the sy	mptoms ap	pear suddenly?							
		e of onset kr	iown?							
	Exact time: hrs (24 hour clock)									
	Do the deficits affect one side of the body?									
	Has the person had a stroke previously?									
	Is the patient known to have diabetes? If yes – has the blood sugar been checked? Note Glucose level mmol/L									
	Is the patient known to have epilepsy? If yes could this be a fit?									
	Has the person had a fall and hit their head?									
	FOR RAPIDLY RESOLVING/RESOLVED TRANSIENT ISCHAEMIC ATTACK, ASSESS USING ABCD(2) SCORE									
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	Age Score		60 or above 1	Other 0			/1			
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## **Observing Neurological and Vital Signs**

Physiological and Neurological monitoring (blood pressure, pulse, temperature, respiratory rate, oxygen saturations, Glasgow Coma Scale and pupil reactions) should be undertaken in all patients for at least 72 hours following admission. Frequency of observations should be appropriate to the patient's condition i.e. continual or every 15 mins if unstable and reducing in frequency as the patient's condition stabilises. Minimum recording of 4 times per 24hrs in the acute phase

Observations should also be undertaken at night/during sleep if appropriate.

#### Use EWS/ Neurological Observation Recording card

		Frequency of Observations		
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Name:

**Hospital Number:** 

Initial &

Day 1

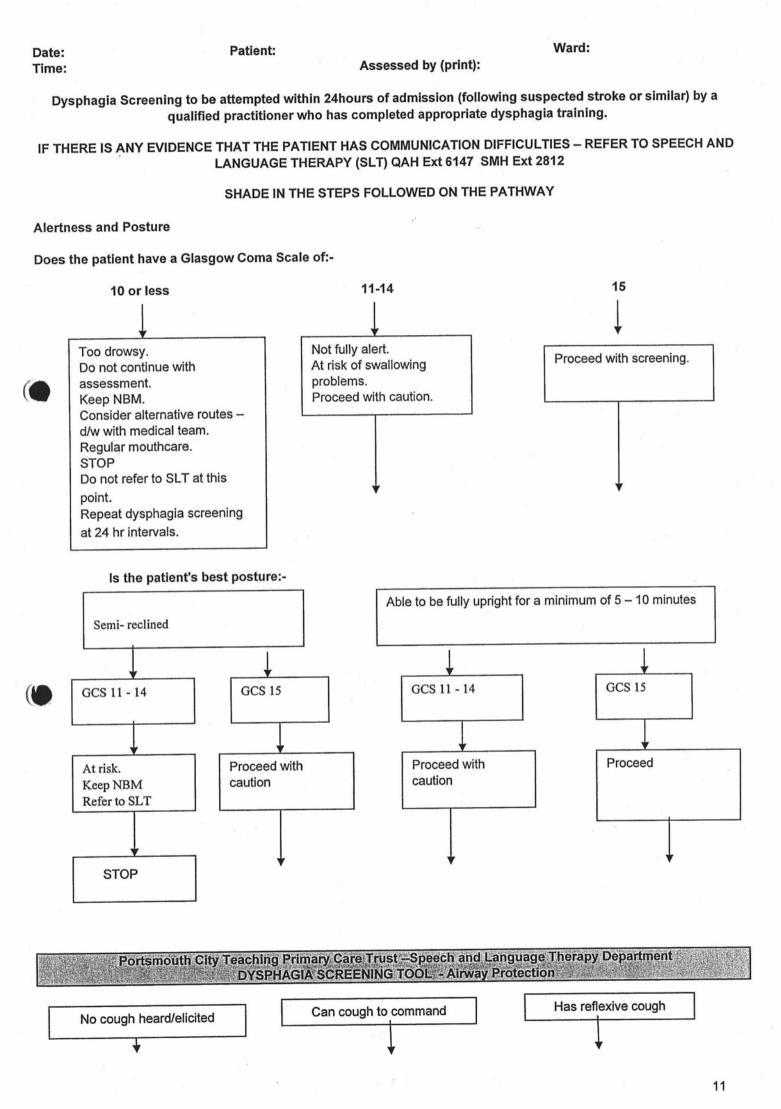
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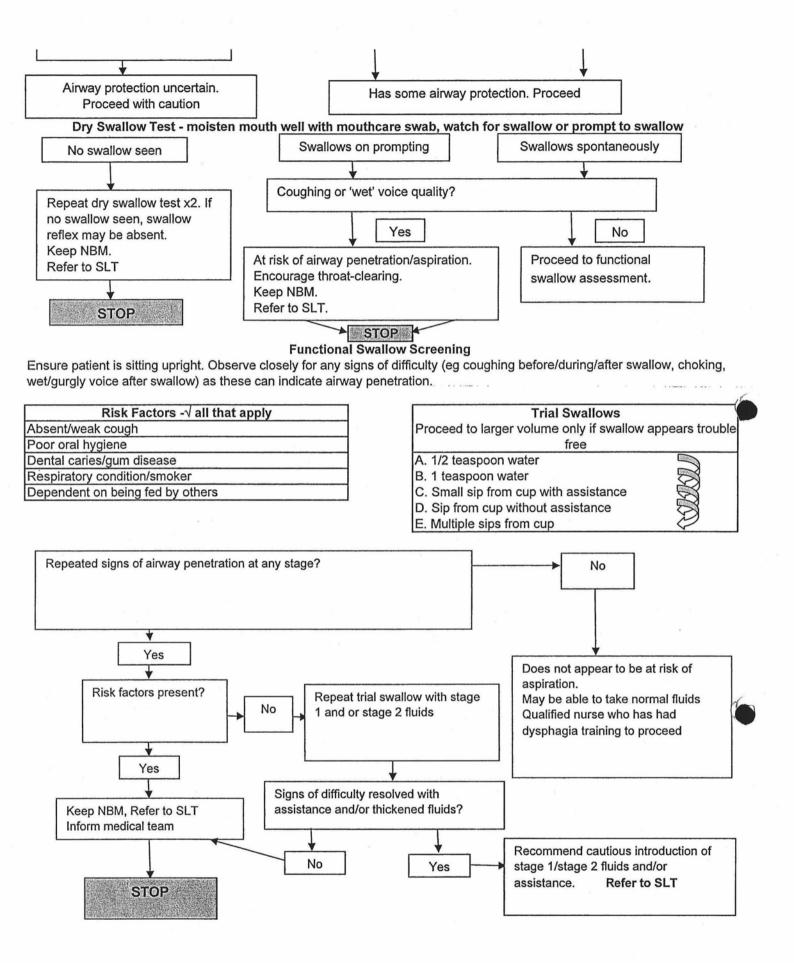
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Date:

1 2	3			
Barthel Index	Score		Pre-	T
Bowels			stroke	Current
0 = incontinent (or needs to be given enemas)			SHOKE	
1 = occasional accident				
2 = continent				
Bladder				
0 = incontinent, or catheterized and unable to manage alone				
1 = occasional accident				
2 = continent				
Grooming				
0 = needs to help with personal care			×	
1 = independent face/hair/teeth/shaving (implements provided) Dressing		****		
-				
0 = dependent				
1 = needs help but can do about half unaided				
2 = independent (including buttons, zips, laces, etc.)				
Toilet Use				-3
0 = dependent				
1 = needs some help, but can do something alone				
2 = independent (on and off, dressing, wiping)				
Feeding				
0 = Unable				
1 = needs help cutting, spreading butter etc.		8.0		
2 = independent				
Transfers (bed to chair and back)				
0 = unable, no sitting balance				1
1 = major help (one or two people, physical),				
2 = minor help (verbal or physical)		· · · ·		
3 = independent				
Mobility (on level surfaces)				
0 = immobile				÷ i
1 = wheelchair independent, including corners				
2 = walks with help of one person (verbal or physical)				
3 = independent (but may use any aid; for example, stick)				
Stairs				
0 = unable			*	
1 = needs help (verbal, physical, carrying aid)				(
2 = independent	-			
Bathing				
0 = dependent				
1 = independent (or in shower)				
		TOTAL =	/20	/20
Stratify Falls Risk Assessment Tool				
1. Has the patient presented to hospital with a fall or fallen since	admission?	Yes = 1, No =	0	
Do you think the patient is:-				
2. Agitated? Yes = 1, No = 0				
<ol><li>Visually impaired to the extent that everyday function is affected</li></ol>	d Yes = 1, N	o = 0		
4. In need of especially frequent toileting? Yes = 1, No = 0				
5. Transfer and mobility score 3 or 4? Yes = 1, No = 0				
Date Score Date Score Date Scor	e Date	Score	Date	Score

Portsmouth City Teaching Primary Care Trust —Speech and Language Therapy Department DYSPHAGIA SCREENING TOOL





	Name:	e: Hospital Number:						
Initial & date sections	Medical Clerking - History							
30010113	Date	/ / Time : hrs Name: Signature: Bleep:						
	Histor	ory of presenting complaint and <u>exact</u> time of onset:						
			-					
	Past	Medical History						
]								
	Strok	ke Risk Factors (HT, AF/PAF, IHD, smoking, ETOH, BMI, DM, thrombolphylias)						
	1							
· · · · · · · · · · · · · · · · · · ·								
L								

Name:		Hospi	tal Number:						
& ns	Medical Clerking - History								
Date / / Family History	Time :	hrs Name:	Signature:	Bleep:					
Social History a	and Home Envir	onment							
Medications on Medication		ose F	requency	Comments					
a an suite suite state de constante de constant de la constant de la constant de la constant de la constant de									
Systems Enqui	ſy								

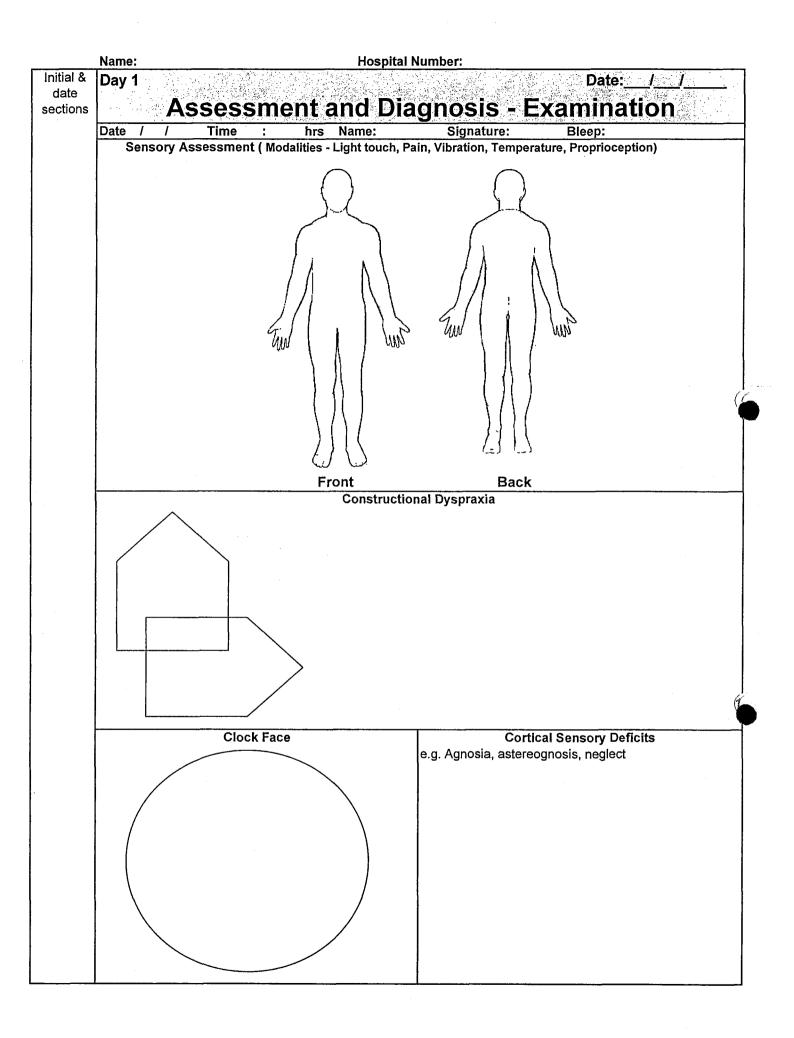
	Name: Hospital Number:	
Initial & date	Day 1 Date:/_/	
sections	Assessment and Diagnosis - Examination	
	Date / / Time : hrs Name: Signature: Bleep: General Appearance	-
		-
	Anaemia	
	Cyanosis	
	Jaundice	
	Clubbing	
	Lymphadenopathy	
	Breasts	
$(\bullet)$	CARDIOVASCULAR SYSTEM	
	Blood Pressure	
	Pulse	
	JVP	
	Heart soundsI II Added sounds	
	Oedema	
	Carotid Bruits	
	Peripheral pulses	
	Capillary refill	
	RESPIRATORY SYSTEM	
	Trachea	
	Percussion note	
	Breath sounds	
	Added sounds	
	Respiratory Rate SaO2 % Air: Oxygen(% & flow rate):	

Name:		Но	spital Number:		
Day 1				Date: /	
s	∖ssessm	ent and	Diagnosis	s - exami	nation
Date / /	Time :	hrs Name	: Signa	ature:	Bleep:
Masses			ABDOMEN		
Liver			$\sim$	$\sim$	1
Kidneys					
•				o	
Spleen				$\land$	
Tenderness				$\sim$	$\sim$
rendemess					
Bowel sounds					
Joints, bones,	deformities	LOC	COMOTOR SYSTEM		
bolina, bolica,	ucionnaica				
Document any	y Falls History. Fa	ulls risk? - ensu	re patient on falls pa	athway	
<u> </u>					

	Name:	Hospital Number:	
Initial &	Day 1	Date:_	<u> </u>
date sections	Assessment and I	Diagnosis - Exar	nination
	Date / / Time : hrs Na	ame: Signature:	Bleep:
		RVOUS SYSTEM	
	Communication Can patient communicate normally?	Yes	No
			.I
	Aphasia (impairment of language affecting understand speaking, reading and/or writing)	ding, Yes	No
	Dysarthria (slurred speech, may co-exist with aphasia	<sup>a)</sup> Yes	No
	Hand Dominance	Right	Left
	Other		
	Referred to Speech and Language Therapy?	Yes	No
	Mental state		
	Oriented?	Yes	No
	Does the patient have capacity to make decis related to their care? (Document as per Trust		No
	AMT: 1. Age 2. Time to the nearest hour 3. Give address for recall at the end of the tes repeated by the patient to ensure that it has b 42 West Street 4. Year		
)	<ol> <li>5. Name of Institution</li> <li>6. Recognise two persons (doctor, nurse etc.</li> <li>7. Date of birth</li> </ol>	)	
	8. Year of the First World War 9. Name of the present monarch		
	10.Count backwards from 20 to 1		
	Recall address	TOTAL:	/10
	Mood		
	Other neurological conditions (eg Parkins	on's disease, myasthenia gravis	s etc)

Name:		ospital Number: Date:	<u> </u>	
Day 1			이는 이번에 이번에 있는 것이 같아요. 이번에 가지 않는 것이 있는 것이 없는 것이 있는 것이 없는 것이 않는 것이 없는 것이 같이 않는 것이 없는 것이 것이 없는 것이 없이 없는 것이 있 않이 않는 것이 없는 것이 없 것이 없는 것이 않이	- 注意したと思われるのではなみない。 ひかなわしい
A	ssessm	ent and D	iagnosis - E	xamination
Date /	/ Time	: hrs Nam	e: Signature IIAL NERVES	: Bleep:
Eyes	······			
Pupils	Size	Reaction	Lia	ht/Accommodation
Fupiis	012C	Redetion	3	,
Nystagmi	us	н	lorner's syndrome	
Acuity (II)	)			
Field Defe	ects (what patier	nt sees)	Left	Right
			(	) [
	1			
Fundi				
Eye move	ements (III, IV, V	I)		
Face Motor (VI	I)		-	
Sensory (	(V)			
Mouth	of mastication (	~		
Muscles	of mastication (	• )		
Tongue (	X(I)			
Pharynx				
Motor (X) Sensory (				
Voice (X)				
Ears	<u></u>			- 4. <u></u>
Hearing Weber's				
Rinne's to				
External	auditory canal			
Neck (XI	1	· · · · · · · · · · · · · · · · · · ·	······································	

	Name:	Hospital Number:								
Initial &	Day 1	Date:/								
date sections	Assessment and Diagnosis - Examination									
		me: Signature: DR ASSESSMENT	Bleep:							
	UPPER LIMBS	Right	Left							
	Tone									
	Wasting									
	Power (specify group) & MRC grade (NB Ton	e/spasticity)								
	Drift									
	Shoulder									
	Elbow									
	Wrist									
	Fingers Fasiculation									
	Ataxia (Finger/Nose) REFLEXES TJ (C7,8)									
	BJ (C5,6)									
	SJ (C5,6) LOWER LIMBS	Right	Left							
	Gait									
	Tone									
	Wasting									
	Power (specify group) & MRC grade (NB tone	∋/spasticity)								
	Hip									
	Knee									
	Ankle Fasiculation									
	Ataxia (Heel/Toe)	•								
	REFLEXES KJ (L3,4)									
	AJ (S1,2)									
	Plantars									
	Clonus									



	Name:		Hospital Num	ber:	
Initial & date	Day 1			Date:/	
sections		Summ	arv of Clin	ical Findin	gs
	Summary			<u> </u>	<u> </u>
					·
				<u></u>	
	Likely clinical diag	noses, site and ca PACI	ause (for example L T/	ACI secondary to AF (er	mbolic stroke) Other
	PICH	SAH	Mixed	1999 - A.A. A. M. M. MARANA AND AND AND AND AND AND AND AND AND	
<b>7</b>					
		<u> </u>			
	Investigations				
	Management	<u> </u>			
			•		

Initial & Day 1

Assessment			ical Review	n nel antar a manera da aparte da esta emanera	And a second
Consultant Review D Diagnoses:	Date / /	Time :	hrs	Name:	
Plan:					
			**		
Investigations:					
Results					
Outstanding					
Treatment:					
Diagnosis, Prognosis a (include data and time a				ussed and recorded	l using DNAR form
,					
Interventions/Secondar Blood Pressure Manager			Anti-plate	lets	
			Anti-coag	ulants	
Analgesia/antipyretic	25-2		Statin		

Initials	Date / / Time : hrs		Initials	Date /	1	Time	: -	hrs
	Assessment/monitoring				Interve	ntions		
和我们的?	All base line observations		<b>学校教育教育</b>	I.V. Fluids	A.S. M. CARE & C.S. F. D. F.			
	Diabetes		的自己的意思	Stop anti				
	DVT risk - graduated pressure stockings		關於南部國家					e lowering
	Tissue viability		和其他的情報	Catheter	ONLY i	if in urina	ry rete	ention
	Swallow screen			Antipyretic	CS			
	Nutrition			Oxygen				8
	Bowel			Hyperglyc	aemia			× +
	Bladder			Oral hygie	ene			
· 11月1月1日日	Fluid balance		12000000000000000000000000000000000000	Psycholo	gical s	upport ar	nd info	rmation -
	Mini mental test		1日日本市1月10日(1993年) 日本市場を設けた。日本市1	patient a	nd relat	tives	CELONAL	
	Other			Pain conti	rol - avc	oid opiates	;	
	]							
Referral to	o Neurosurgery indicated		Y	ES			N	10
If yes:	D	ate	1	1	Tin	no	1	hrs
			/	/		ne		
Outcome	of referral:							
Initials	Date / / Time : hrs		Initials	Date /	1	Time	:	hrs
	Diagnostics				Refe			
的问题的	CT scan (if not already done)		<b>这一次这一次</b>	Clinical S			or	建筑和自己设计
	Chest X-Ray			CNS Acqu				
	Full routine blood & coag screen			Speech a		guage The	erapy	
法法律性理论	ECG			Physiothe				11 L
	Echo			Occupatio				
	MRI / MRA			Consultar				
	CT with contrast			Consultar		trician/stro	oke phy	sician
	Carotid Doppler	8		ΙΤυ/CCU/	ΉDU			
	TTE/TOE			CSRT				
	Vasculitis screen			Other				
	Other							
	Infection	n Control S	creening			XI. SAMA		
low cu	rrent guidance/policy and record results:							* *
1								
1	- to notiont and familier		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
Informatio	on to patient and family:							
2								

	Name:	Hospital Number:
Initial &	Day 1	Date: / /
Initial & date	Day I	Dates
sections		
	Ca	re 3-24 hours

A	ssessment and	Monitoring	Nursin	g and A	HP	Revi	ew			
		full vital signs	and neurol	ogical obs	ervati	ons a	nd reco	rd freq	uency rec	quired.
W	k <b>in Integrity</b> /aterlow Score: quipment:			Date	1 1		Time	:	hrs	
	ositioning, Movi	-	-		ASSI		ACH T		EFORE A UVRE	TTEMPT
Ri	sk assessment	document co	mpleted		i de C	ate	$l = l^{-1}$	T ve	ime :	hrs
	onsider Falls Ri	sk and mana	gement in	line with	Trust	Falls	Policy		<b>波带</b> 流行	
M	obility									
lf i	easured for anti-entimet applied, state	reason	-				Siz			
	ood and Drink	Completed	Nutrition	al Screen Date	ing A / /		sment a Time	and file	e here hrs	
				Initials:						
Re	esult and recomm	iendations								
Re	eferral to SLT			Date	1 1		Time	:	hrs	
W	eight:		<b>这时的</b> 有些没有	Date	$I \sim I$		Time		hrs	
Fo	ood and fluid intal	ke/output reco	rd commer	iced	D	ate	/ /	Ti	me :	hrs
EI	imination									
	× .									
BI	adder scan			Date	/ /		Time	:	hrs	
	adder scan	- 		Date Hospita				:	hrs	
Na				Hospita	al Nur	<sup>nber:</sup> Date	<b>:</b>	12.15	Several sectors and	
Na	ame:		Care	Hospita	al Nur I h	<sup>mber:</sup> Date OU	e: rs	12.15	Several sectors and	
Na D	ame:	Aonitoring	AN TRADE OF ALL DESCRIPTION	Hospita	al Nur I h	<sup>mber:</sup> Date OU	e: rs	12.15	Several sectors and	

1				<sup>1</sup> I
Vision:				
Hearing:				
Hygiene and self-care status:				
Oral Hygiene:				
Pain/Distress/Comfort				
Palliative Care Indicated:				
Discussed with MDT	Date / /	Time :	hrs	
Discussed with NOK				
	Data / /	Time :	hrs	
Liverpool Care Pathway commenced Name:	Date / / Ho	ospital Number:	n han the spin to be discounted and the	
Day 1		10月1日日 日本日本日本日本日本日本日本日本日本日本日本日本日本日本日本日本日本日本	: <u> </u>	
MDT Pro	gress/Con	tinuatio	n Notes	
Predictive date of discharge:				
a second of the second s				

					****	
an - An - Marina a sharan an ar an	A BAR BAR, "AutoMateur, I'm Bar ag Anno. A' Anno Anno Anno. A' Anno Anno Anno. Anno Anno. Anno Anno An	######################################				
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5 Charles Mandel Andrews, S. 1997, St. 2010, S Control Mandel Science Management (1997)	anna a tha an an an anna an anna an anna an ann ann ann an a		*****	*****	<b></b>	
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#### Name:

### Hospital Number:

Initial &	Day 2				Med	ica	l Rev	Date: <u>///</u> /
	Assessment Consultant Review Diagnoses:	Date	1	1	Time	:	hrs	Name:
	Plan:							

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		Investigations:		
		Results		
		Outstanding		
		Outstanding		
		Treatment:		
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		Prognosis and Review of Resuscitation Status dis	cussed and recorded using DNAR form (include d	ata
		and time and with whom discussed )		
		Interventions/Secondary Prevention		
		Blood Pressure Management	Anti-platelets	
			Anti-coagulants	
		Analgesia/antipyretic		
			Statin	
		Information to patient and family:		
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	Name:					Но	spital Nu	nber:			
Initial & date	Day 2						Date:_	!	<u></u>		
sections											
	Assessment and Monitoring										
	Continue fu	II vital signs	and neurologica	al ob	serv	ation	and reco	rd frequ	uency req	uired.	
	Skin Integrity										
	Waterlow Score:		D	ate	1	1	Time	:	hrs		
	Equipment:										
	2										

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Mobility	RISK	ASSESS	EACH TI ANY MA		FORE ATT	EMPTII
Anti-embolic stockings worn: If not applied, state reason			Siz			
Food and Drink Rescore Nutri	tional Screeni					
Swallow screen completed	Date / Initials:	/	Time	:	hrs	
Result and recommendations	initiais.		,			
Weight:	Date	1 - 1	Time		hrs	
Food and fluid intake/output record co	mmenced	Date	1 1	Tim	ie :	hrs
Elimination						
Bladder scan	Date	/	Time	:	hrs	

Name:

Hospital Number:

Initial & date	Day 2	Date://
sections	Nursing and	d AHP Review
	Assessment and Monitoring	
	Communication	
	· · · ·	
1		

Vision:						
Hearing:						
Hygiene and self-care status:				<u></u>		
Oral Hygiene:						
Pain/Distress/Comfort			_			
Palliative Care Indicated:						
Discussed with MDT	Date	1	Ι	Time :	hrs	
Discussed with NOK						
Liverpool Care Pathway commenced	Date	1	1	Time :	hrs	

	Name:	Hos	pita	l Num	ber:		
Initial & date	Day 2	D	)ate	e:	<u> </u>		
sections	Referral to Reha	abilita	atio	on			
	Is early transfer home appropriate?					Y	N
	Does patient fulfil Community Stroke Rehabilitation	Гeam C	rite	ria?		Y	N
	Record decision and referral details:	Date	1	1	Time	:	hrs
							~
	Details added to list:	Date	1	1	Time	:	hrs
	Does the patient require in-patient rehabilitation?					Y	N
	Record decision and referral details:	Date	1	1	Time	:	hrs
	Details added to list:	Date	1	1	Time	:	hrs
	Ear advice regarding republication contact						·
	For advice regarding rehabilitation contact:		re:	bln 1	264 x 2	2515	
	Dr Jane Williams, Consultant Nurse in Stro Ruth Davies, Clinical Stroke Coordinator: b	ke Ca Ip 178	38 x	6731	1	2515	
	Dr Jane Williams, Consultant Nurse in Strol Ruth Davies, Clinical Stroke Coordinator: b Flora McMullon, Clinical Nurse Specialist (A	ke Ca lp 178 ABI): b	38 x olp	673′ 1926	l x 6731		
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	Name:	Hospital Number:
	Day 2	Date: / /
sections		MDT Progress/Continuation Notes
	Predictive dat	e of discharge:
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	agement (see guidelines). Check renal function bone profile and alk.phos. levels
Abnormal	Previous fragility fracture? Yes No
Action taken:	
Action taken.	

	Name:		Hospital Number:		
Initial & date	Day 3		Date:/_	<u> </u>	
sections			AHP Review		
	Decrease Nutrition and fluids:	frequency of vital signs and r	neurological observation	s as appropriate.	
	Elimination:				
	Hygiene and skin integrity	v:			
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	Mobility:			H TIME BEFORE ATTE MANOEUVRE	MPING
-	Positioning:				
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	Communication:				
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	Rest and Sleep:				
	Cognition and Perception	:			
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	Information - patient and f	family:			
	Other:				
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Name:	Hospital Number:
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	Name:	Hospital Number:
Initial & date	Day 4	Date://
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	Hygiene and skin integrity:
	Mobility: RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE
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	Mobility:	Stairs:	Bathing:	
		Transfer/Disc	harge Plans	
		Transiendisc	inarge i lans	

	Date / / T	ime :	hrs	
Patient informed:	Date / / T	îme :	hrs	
NOK informed:		Date / / T	ime :	hrs
Transfer of care document co	ompleted: copied and given to patient	Date / / T	îme :	hrs
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Secondary F	Prevention Checklist - iden	ify problem and man	agement pl	an
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Antiplatelet therapy	And-Coagulation therapy	Diabetes		
Carotid Stenosis	Hypercholesterolaemia	Weight/Diet		
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Updated: 12 January 2009

Department	DSN	PA/Secretary
DMOPS	Gill Gould	Sue Bird - 6894
Clinical Support Services (CSSD)	Fiona McNeight	Denise Hollies - 6709
Surgical	John Fletcher	Admin Surgical Temp - 5796
W&C	TBA (ctc Donna Ockenden)	Michelle Moore -7701 2552
Medical	Maria Edens	Pauline Warren - 5400

Department	DGM	PA/Secretary
DMOPS	Lesley	Pat Loader - 6941
	Humphrey	
Clinical Support Services (CSSD)	Steve Marper	Denise Hollies - 6709
Surgical	Felicity Greene	Alison Moore - 6287
W&C	Donna Rowell	Michelle Moore -7701 2552
Medical	Gillian Dewey	Pauline Warren - 5400

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