Portsmouth Hospitals NHS
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

Patient Transfer History

Ward/Unit	Date	Time	Comment
Admission			
1			
2			
3			
4			

STROKE IS A MEDICAL EMERGENCY 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:

Acute Stroke Pathway - signature record

Acute Stroke Pathway - Signature record

Date and sign/initial *all* entries in this document

Name	Signature	Initials	Date & Time

Initial & date sections

Acute Stroke Pathway - patient details

Name:	Date of admission: ____/____/_____
D.O.B. Gender: M F	Time of admission: ____:____hrs
Address:	Hospital No:
	GP Name:
	Address:
Post code:	
Home telephone No:	Telephone No:

Religion	Nationality	Marital Status

Next of Kin 1: Relationship:

Address:

Telephone No:

Next of Kin 2: Relationship:

Address:

Telephone No:

Other significant information:

Resuscitation status: Date: ____/____/_____

DNAR form completed if appropriate: Y N

Known allergies:

Special needs: (e.g. hearing, vision, language)

Other professionals/services involved:

Name and contact details:

Name and contact details:

Name and contact details:

Definitions/Descriptions

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.

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 scale 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.

Name: **Hospital Number:**

Acute Stroke Pathway - Summary of Referrals

Date	Referred to	Purpose	Signature

Name: Hospital Number:

Initial & date sections

Acute Stroke Pathway - "FAST"

Face	Can the person smile, showing their teeth? Are their face and/or eyes symmetrical when they smile?
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.
Speech	Can the person speak to you by repeating a phrase and understand what is being said to them? Is their speech slurred?
Test	All three symptoms – if at least one out of three demonstrate a deficit, then suspect a stroke.

Consider these points	Y	N
Did the symptoms appear suddenly?		
Is the time of onset known? 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

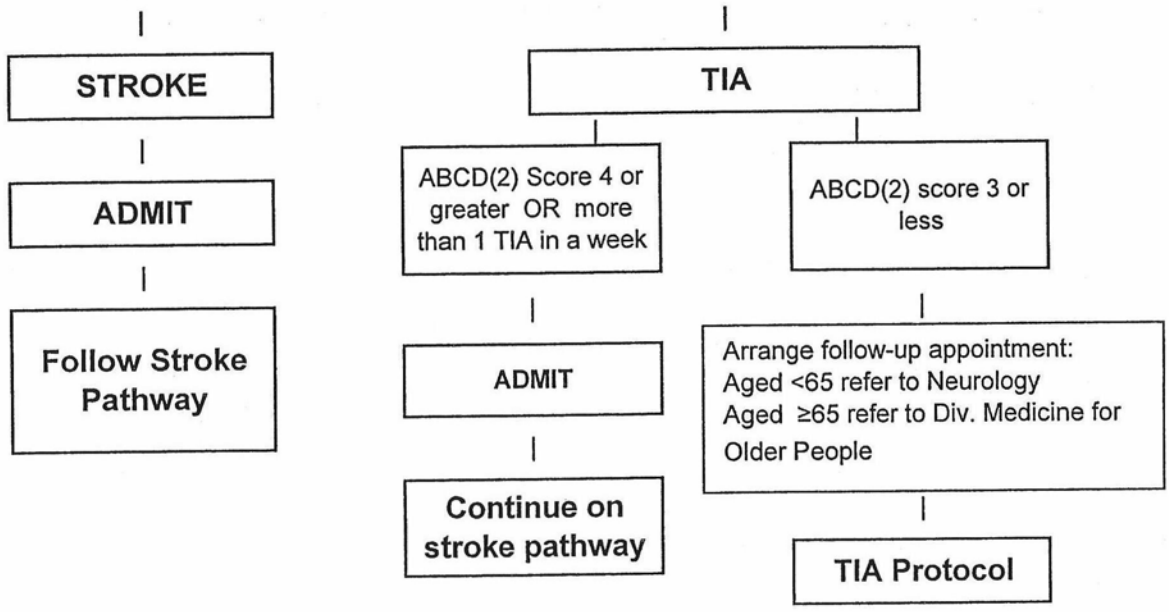
				Score
Age *Score*	60 or above 1	Other 0		/1
Blood pressure *Score*	Systolic >140 and/or Diastolic ≥90 1		Other 0	/1
Clinical Features *Score*	Unilateral weakness 2	Speech disturbance without weakness 1	Other 0	/2
Duration *Score*	≥60 minutes 2	10-59 minutes 1	<10 minutes 0	/2
Diabetes	Diabetic 1	Non-Diabetic 0		/1
Total				/7

STOP! If ABCD score is 4,5 ,6 or 7 OR patient has had more than 1 TIA in a week keep as in-patient until investigations and primary prevention measures instigated. If discharging follow TIA protocol

Name: Hospital Number:

Initial & date sections

Preliminary Diagnosis Pathway



Preliminary Diagnosis = STROKE

Inform:

Clinical Stroke Coordinator: Bleep 1788 or ext. 7700 6731

Or

Clinical Nurse Specialist (acquired brain injury) under 65 years only: Bleep 1926 or ext. 7700 6731 (Office hours)

Or

Patient Flow Team: Bleep 1265 (09.00-21.00hrs)

Request *URGENT* CT Scan or other neuro-imaging

Form completed and taken to CT - Date ____/____/_____ Time ____:____ Signed.....

Preliminary report

Hyper-Acute Treatments

Ischaemic stroke - Consider Thrombolysis. Refer to protocol
TREATMENT NOT YET AVAILABLE
Large MCS occlusion - seek early neurosurgery opinion for ?decompressive surgery

Haemorrhagic stroke - Consider Neurosurgical opinion

For refer to Southampton Neuro-Surgical Team use internet: www.neurorefer.co.uk and also inform neurosurgical registrar via bleep on 02380 777222 or # 6215

Name: Hospital Number:

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

Date	Time	Frequency/special instructions	Signature

Name: Hospital Number:

Acute Stroke Pathway - Summary of Blood Tests

Date									
Time									
Hb									
WBC									
Plt.									
PCV									
MCV									
Diff									
ESR									
B12									
Folate									
Ferritin									
INR									
APTR									
Urea									
[redacted]									
Creat									
Glucose									
Phosphate									
Calcium									
Bilirubin									
Total prot.									
Albumin									
ALP									
AST									
Adj Ca2+									
CK									
Magnes'									
CRP									
Trop 1									
Free T4									
TSH									
[redacted]olest'									
pH									
PCO2									
PO2									
SB									
BE									
SATs									

Name: **Hospital Number:**

Initial &	Day 1	Date: / /
	Assessment and Diagnosis - Clerking	

Assessment and Diagnosis - Clerking

NIHSS score

1 2 3

Barthel Index	Score	Pre-stroke	Current
Bowels 0 = incontinent (or needs to be given enemas) 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 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. 2 = independent			
Transfers (bed to chair and back) 0 = unable, no sitting balance 1 = major help (one or two people, physical), 2 = minor help (verbal or physical) 3 = independent			
Mobility (on level surfaces) 0 = immobile 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
3. Visually impaired to the extent that everyday function is affected Yes = 1, No = 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	Score	Date	Score	Date	Score

A score of 2 or more = patient at high risk of falling = start Falls Risk Patient Pathway

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

Date: **Patient:** **Ward:**
Time: **Assessed by (print):**

Dysphagia Screening to be attempted within 24hours of admission (following suspected stroke or similar) by a qualified practitioner who has completed appropriate dysphagia training.

IF THERE IS ANY EVIDENCE THAT THE PATIENT HAS COMMUNICATION DIFFICULTIES – REFER TO SPEECH AND LANGUAGE THERAPY (SLT) QAH Ext 6147 SMH Ext 2812

SHADE IN THE STEPS FOLLOWED ON THE PATHWAY

Alertness and Posture

Does the patient have a Glasgow Coma Scale of:-

10 or less

Too drowsy.
Do not continue with assessment.
Keep NBM.
Consider alternative routes – d/w with medical team.
Regular mouthcare.
STOP
Do not refer to SLT at this point.
Repeat dysphagia screening at 24 hr intervals.

11-14

Not fully alert.
At risk of swallowing problems.
Proceed with caution.

15

Proceed with screening.

Is the patient's best posture:-

Semi- reclined

GCS 11 - 14

At risk.
Keep NBM
Refer to SLT

STOP

GCS 15

Proceed with caution

Able to be fully upright for a minimum of 5 – 10 minutes

GCS 11 - 14

Proceed with caution

GCS 15

Proceed

Portsmouth City Teaching Primary Care Trust –Speech and Language Therapy Department
DYSPHAGIA SCREENING TOOL - Airway Protection

No cough heard/elicited

Can cough to command

Has reflexive cough

Airway protection uncertain. Proceed with caution

Has some airway protection. Proceed

Dry Swallow Test - moisten mouth well with mouthcare swab, watch for swallow or prompt to swallow

No swallow seen

Repeat dry swallow test x2. If no swallow seen, swallow reflex may be absent.
Keep NBM.
Refer to SLT

STOP

Swallows on prompting

Swallows spontaneously

Coughing or 'wet' voice quality?

Yes

At risk of airway penetration/aspiration.
Encourage throat-clearing.
Keep NBM.
Refer to SLT.

STOP

No

Proceed to functional swallow assessment.

Functional Swallow Screening

Ensure patient is sitting upright. Observe closely for any signs of difficulty (eg coughing before/during/after swallow, choking, wet/gurgly voice after swallow) as these can indicate airway penetration.

Risk Factors -√ all that apply
Absent/weak cough
Poor oral hygiene
Dental caries/gum disease
Respiratory condition/smoker
Dependent on being fed by others

Trial Swallows

Proceed to larger volume only if swallow appears trouble free

A. 1/2 teaspoon water
B. 1 teaspoon water
C. Small sip from cup with assistance
D. Sip from cup without assistance
E. Multiple sips from cup

Repeated signs of airway penetration at any stage?

Yes

Risk factors present?

Yes

Keep NBM, Refer to SLT
Inform medical team

STOP

No

Repeat trial swallow with stage 1 and or stage 2 fluids

Signs of difficulty resolved with assistance and/or thickened fluids?

No

Yes

Recommend cautious introduction of stage 1/stage 2 fluids and/or assistance. **Refer to SLT**

No

Does not appear to be at risk of aspiration.
May be able to take normal fluids
Qualified nurse who has had dysphagia training to proceed

Name: Hospital Number:

Initial & date sections

Medical Clerking - History

Date / / Time : hrs Name: Signature: Bleep:

History of presenting complaint and exact time of onset:

Past Medical History

Stroke Risk Factors (HT, AF/PAF, IHD, smoking, ETOH, BMI, DM, thrombolphylias)

Name: Hospital Number:

Initial & date sections

Medical Clerking - History

Date / / Time : hrs Name: Signature: Bleep:

Family History

Social History and Home Environment

Medications on admission

Medication	Dose	Frequency	Comments

Systems Enquiry

Name: Hospital Number:

Initial & date sections

Day 1 **Date:___/___/_____**

Assessment and Diagnosis - Examination

Date / / Time : hrs Name: Signature: Bleep:

General Appearance

Anaemia

Cyanosis

Jaundice

Clubbing

Lymphadenopathy

Breasts

CARDIOVASCULAR SYSTEM

Blood Pressure

Pulse

JVP

Heart sounds ---------I---------- II---------- Added sounds

Oedema

Carotid Bruits

Peripheral pulses

Capillary refill

RESPIRATORY SYSTEM

Trachea

Percussion note

Breath sounds

Added sounds

Respiratory Rate SaO_2 % Air: Oxygen(% & flow rate):

Name: **Hospital Number:**

Initial & date sections

Day 1 **Date:** __/__/____

Assessment and Diagnosis - examination

Date / / **Time** : **hrs** **Name:** **Signature:** **Bleep:**

ABDOMEN

Masses

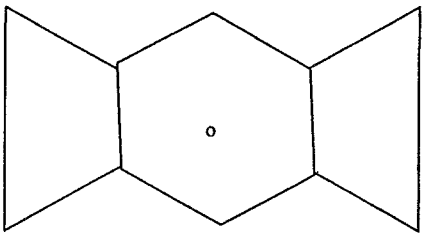
Liver

Kidneys

Spleen

Tenderness

Bowel sounds



LOCOMOTOR SYSTEM

Joints, bones, deformities

Document any Falls History. Falls risk? - ensure patient on falls pathway

Name: **Hospital Number:**

Initial & date sections

Day 1 **Date:___/___/_____**

Assessment and Diagnosis - Examination

Date / / Time : hrs Name: Signature: Bleep:

NERVOUS SYSTEM

Communication

Can patient communicate normally?	**Yes**	**No**
Aphasia (impairment of language affecting understanding, speaking, reading and/or writing)	**Yes**	**No**
Dysarthria (slurred speech, may co-exist with aphasia)	**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 decisions related to their care? (Document as per Trust Policy)	**Yes**	**No**

AMT:

1. Age
2. Time to the nearest hour
3. Give address for recall at the end of the test. This should be repeated by the patient to ensure that it has been heard correctly

42 West Street

4. Year
5. Name of Institution
6. Recognise **two** persons (doctor, nurse etc.)
7. Date of birth
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 Parkinson's disease, myasthenia gravis etc)

Name: Hospital Number:

Initial & date sections

Day 1 Date: __/__/____

Assessment and Diagnosis - Examination

Date / / Time : hrs Name: Signature: Bleep:

CRANIAL NERVES

Eyes

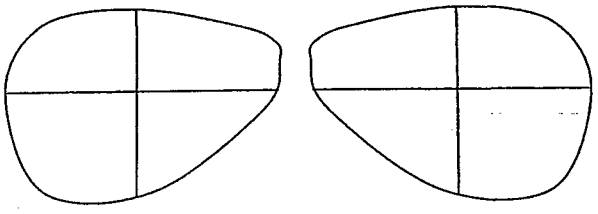
Pupils **Size** **Reaction** **Light/Accommodation**

Nystagmus **Horner's syndrome**

Acuity (II)

Field Defects (what patient sees)

Left Right



Fundi

Eye movements (III, IV, VI)

Face
Motor (VII)

Sensory (V)

Mouth
Muscles of mastication (V)

Tongue (XII)

Pharynx
Motor (X)
Sensory (IX)
Voice (X)

Ears
Hearing (VIII)
Weber's test

Rinne's test

External auditory canal

Neck (XI)

Name: **Hospital Number:**

Initial & date sections

Day 1 **Date:__/__/____**

Assessment and Diagnosis - Examination

Date / / Time : hrs Name: Signature: Bleep:

MOTOR ASSESSMENT

UPPER LIMBS	**Right**	**Left**
Tone		
Wasting		
Power (specify group) & MRC grade (NB Tone/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 Number:

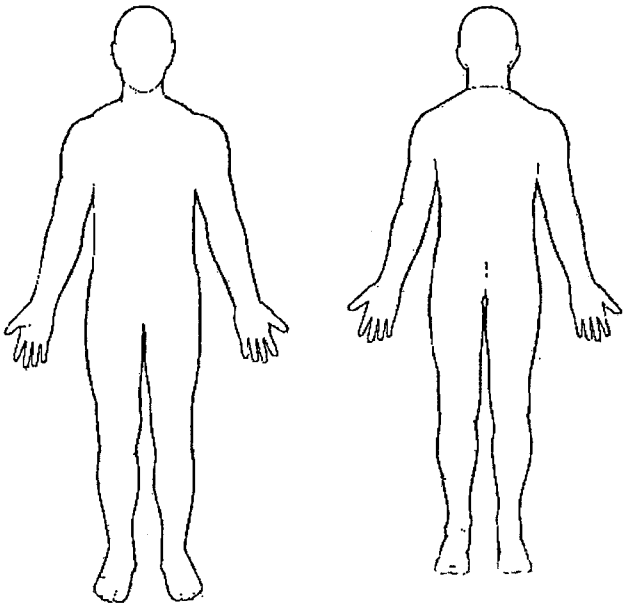
Initial & date sections

Day 1 Date: ___/___/_____

Assessment and Diagnosis - Examination

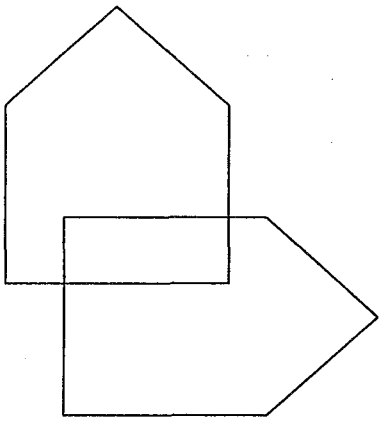
Date / / Time : hrs Name: Signature: Bleep:

Sensory Assessment (Modalities - Light touch, Pain, Vibration, Temperature, Proprioception)

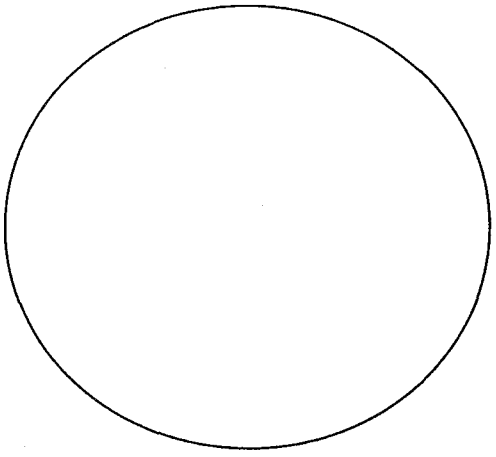


Front Back

Constructional Dyspraxia



Clock Face



Cortical Sensory Deficits

e.g. Agnosia, astereognosis, neglect

Name: Hospital Number:

Initial & date sections

Day 1 Date:___/___/_____

Summary of Clinical Findings

Summary

Likely clinical diagnoses, site and cause (for example L TACI secondary to AF (embolic stroke)

TACI	PACI	LACI	POCI	Other
PICH	SAH	Mixed		

Investigations

Management

Name: Hospital Number:

Initial & Day 1 Date: / /

date sections

Day 1 Date: ___/___/_____

Care 3-24 hours

Medical Review

Assessment
Consultant Review Date / / Time : hrs Name:
Diagnoses:

Plan:

Investigations:

Results

Outstanding

Treatment:

Diagnosis, Prognosis and Review of Resuscitation Status discussed and recorded using *DNAR form* (include data and time and with whom discussed)

Interventions/Secondary Prevention

Blood Pressure Management	Anti-platelets
	Anti-coagulants
Analgesia/antipyretic	
	Statin

Name: **Hospital Number:**

Day 1 **Key:** **Essential** *Consider*

First 3 hours care

Initials	Date / / Time : hrs		Initials	Date / / Time : hrs
	Assessment/monitoring			**Interventions**
	All base line observations			**I.V. Fluids**
	Diabetes			**Stop anticoagulants**
	DVT risk - graduated pressure stockings			**Avoid excessive blood pressure lowering**
	Tissue viability			**Catheter ONLY if in urinary retention**
	Swallow screen			*Antipyretics*
	Nutrition			*Oxygen*
	Bowel			*Hyperglycaemia*
	Bladder			*Oral hygiene*
	Fluid balance			**Psychological support and information - patient and relatives**
	Mini mental test			*Pain control - avoid opiates*
	Other			

Referral to Neurosurgery indicated **YES** **NO**

If yes: **Date** / / **Time** : **hrs**

Outcome of referral:

Initials	Date / / Time : hrs		Initials	Date / / Time : hrs
	Diagnostics			**Referrals**
	CT scan (if not already done)			**Clinical Stroke Coordinator**
	Chest X-Ray			*CNS Acquired Brain Injury*
	Full routine blood & coag screen			*Speech and Language Therapy*
	ECG			*Physiotherapy*
	Echo			*Occupational Therapy*
	MRI / MRA			*Consultant Nurse*
	CT with contrast			*Consultant Geriatrician/stroke physician*
	Carotid Doppler			*ITU/CCU/HDU*
	TTE/TOE			*CSRT*
	Vasculitis screen			*Other*
	Other			

Infection Control Screening

]ow current guidance/policy and record results:

Information to patient and family:

Name: **Hospital Number:**

Initial & date sections

Day 1 **Date:___/___/_____**

Care 3-24 hours

Nursing and AHP Review

Assessment and Monitoring

Continue full vital signs and neurological observations and record frequency required.

Skin Integrity

Waterlow Score: Date / / Time : hrs

Equipment:

Positioning, Moving and Handling **RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE**

Risk assessment document completed Date / / Time : hrs

Consider Falls Risk and management in line with Trust Falls Policy

Mobility

Measured for anti-embolic stockings: Size

If not applied, state reason

Food and Drink **Complete Nutritional Screening Assessment and file here**

Swallow screen completed Date / / Time : hrs
Initials:

Result and recommendations

Referral to SLT Date / / Time : hrs

Weight: Date / / Time : hrs

Food and fluid intake/output record commenced Date / / Time : hrs

Elimination

Bladder scan Date / / Time : hrs

Name: **Hospital Number:**

Initial & date sections

Day 1 Date: ___/___/_____

Care 3-24 hours

Nursing and AHP Review

Assessment and Monitoring

Communication

Vision:

Hearing:

Hygiene and self-care status:

Oral Hygiene:

Pain/Distress/Comfort

Palliative Care Indicated:

Discussed with MDT Date / / Time : hrs

Discussed with NOK

Liverpool Care Pathway commenced Date / / Time : hrs

Name: **Hospital Number:**

Initial &

Day 1 **Date:__/__/____**

MDT Progress/Continuation Notes

Predictive date of discharge:

Name: Hospital Number:

Initial &

Day 2 Date: ___/___/_____

Medical Review

Assessment

Consultant Review Date / / Time : hrs Name:

Diagnoses:

Plan:

Investigations:

Results

Outstanding

Treatment:

Prognosis and Review of Resuscitation Status discussed and recorded using *DNAR form* (include data and time and with whom discussed)

Interventions/Secondary Prevention

Blood Pressure Management

Anti-platelets

Anti-coagulants

Analgesia/antipyretic

Statin

Information to patient and family:

Name: **Hospital Number:**

Initial & date sections

Day 2 **Date:___/___/_____**

Nursing and AHP Review

Assessment and Monitoring

Continue full vital signs and neurological observations and record frequency required.

Skin Integrity

Waterlow Score: Date / / Time : hrs

Equipment:

Positioning	
Mobility	***RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE***
Anti-embolic stockings worn: If not applied, state reason	Size
Food and Drink	**Rescore Nutritional Screening and record on tool sheet**
Swallow screen completed	Date / / Time : hrs Initials:
Result and recommendations	
Weight:	**Date / / Time : hrs**
Food and fluid intake/output record commenced	Date / / Time : hrs
Elimination	
Bladder scan	Date / / Time : hrs

Name: **Hospital Number:**

Initial & date sections	
	Day 2 **Date:___/___/_____**
	Nursing and AHP Review
	Assessment and Monitoring
	Communication

Vision:

Hearing:

Hygiene and self-care status:

Oral Hygiene:

Pain/Distress/Comfort

Palliative Care Indicated:

Discussed with MDT Date / / Time : hrs

Discussed with NOK

Liverpool Care Pathway commenced Date / / Time : hrs

Name: **Hospital Number:**

Initial & date sections

Day 2 Date:___/___/_____

Referral to Rehabilitation

Is early transfer home appropriate?				**Y**	**N**
Does patient fulfil Community Stroke Rehabilitation Team Criteria?				**Y**	**N**
Record decision and referral details:	Date / /	Time	:	hrs	
Details added to list:	Date / /	Time	:	hrs	
Does the patient require in-patient rehabilitation?				**Y**	**N**
Record decision and referral details:	Date / /	Time	:	hrs	
Details added to list:	Date / /	Time	:	hrs	

For advice regarding rehabilitation contact:
Dr Jane Williams, Consultant Nurse in Stroke Care: blp 1264 x 2515
Ruth Davies, Clinical Stroke Coordinator: blp 1788 x 6731
Flora McMullon, Clinical Nurse Specialist (ABI): blp 1926 x 6731
Sarah Easton, Community Stroke Rehabilitation Team Leader: x 2510
Dr David Jarrett, Consultant Geriatrician/stroke: x 6590
Dr Jane Tandy, Consultant Geriatrician /stroke: x 6919

Transfer/Discharge Plans

Destination:	Date / /	Time	:	hrs
Patient informed:	Date / /	Time	:	hrs
NOK informed:	Date / /	Time	:	hrs
Transfer of care document completed:	Date / /	Time	:	hrs

Referrals

1

2

3

4

5

Name: **Hospital Number:**

Initial & date sections

Day 2 **Date:___/___/_____**

MDT Progress/Continuation Notes

Predictive date of discharge:

Name: **Hospital Number:**

Initial & date sections	**Day 3** **Date: ___/___/_____**
	Medical Review
	Bone Health management (see guidelines). Check renal function bone profile and alk.phos. levels: Normal Abnormal Previous fragility fracture? Yes No **Action taken:**

Name: **Hospital Number:**

Initial & date sections	**Day 3** **Date:___/___/_____**
	Nursing & AHP Review
	Decrease frequency of vital signs and neurological observations as appropriate.
	Nutrition and fluids:
	Elimination:
	Hygiene and skin integrity:
	Mobility: ***RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE***
	Positioning:
	Communication:
	Rest and Sleep:
	Cognition and Perception:
	Information - patient and family:
	Other:

Name: **Hospital Number:**

Initial & date sections	**Day 3** **Date:___/___/_____**
	MDT Progress/Continuation Notes
	Predictive date of discharge:

Name: Hospital Number:

Initial & date sections

Day 4 Date: ___/___/_____

Medical Review

Name: Hospital Number:

Initial &

Day 4 Date: ___/___/

date sections	Day 4 Date:___/___/_____
	Nursing & AHP Review
	Decrease frequency of vital signs and neurological observations as appropriate.
	Nutrition and fluids:
	Elimination:
	Hygiene and skin integrity:
	Mobility: ***RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE***
	Positioning:
	Communication:
	Rest and Sleep:
	Cognition and Perception:
	Information - patient and family:
	Other:

Name: **Hospital Number:**

Initial & date sections	Day 4 Date:___/___/_____
	MDT Progress/Continuation Notes

MDT Progress/Continuation Notes

Predictive date of discharge:

Name: Hospital Number:

Initial & date sections

Day 5 **Date: __/__/_____**

Medical Review

Name: Hospital Number:

Initial &

Day 5 Date: / /

date sections

Day 5 Date:___/___/_____

Nursing & AHP Review

Decrease frequency of vital signs and neurological observations as appropriate.

Nutrition and fluids:

Elimination:

Hygiene and skin integrity:

Mobility:

RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE

Positioning:

Communication:

Rest and Sleep:

Cognition and Perception:

Information - patient and family:

Other:

Name: **Hospital Number:**

Initial & date sections

Day 5 **Date:___/___/_____**

MDT Progress/Continuation Notes

MDT Progress/Continuation Notes

Predictive date of discharge:

Name: **Hospital Number:**

Initial & date sections	**Day 6**	**Date:___/___/_____**
	Medical Review	

Name: **Hospital Number:**

Initial & date sections	**Day 6** **Date:___/___/_____**
	Nursing & AHP Review
	Decrease frequency of vital signs and neurological observations as appropriate.
	Nutrition and fluids:

Elimination:

Hygiene and skin integrity:

Mobility:

RISK ASSESS EACH TIME BEFORE ATTEMPTING ANY MANOEUVRE

Positioning:

Communication:

Rest and Sleep:

Cognition and Perception:

Information - patient and family:

Other:

Name: **Hospital Number:**

Initial &

Day 6 **Date:___/___/_____**

MDT Progress/Continuation Notes

Predictive date of discharge:

Name: **Hospital Number:**

Initial & date sections

Day ___ (7 or earlier) **Date: ___/___/_____**

Review Day

Barthel Score **Total:**

Bowels:	Bladder:	Grooming:
Dressing:	Toilet use:	transfers:
Mobility:	Stairs:	Bathing:

Transfer/Discharge Plans

Destination:	Date / / Time : hrs
Patient informed:	Date / / Time : hrs
NOK informed:	Date / / Time : hrs
Transfer of care document completed: copied and given to patient	Date / / Time : hrs

Referrals/Follow-up

1

2

3

4

Secondary Prevention Checklist - identify problem and management plan

Stroke type & treatment	**Hypertension**	**Cardiac Disease**
Antiplatelet therapy	**Anti-Coagulation therapy**	**Diabetes**
Carotid Stenosis	**Hypercholesterolaemia**	**Weight/Diet**
Smoking	**Alcohol**	**Exercise**
Other:		

Name: **Hospital Number:**

Initial & date sections

Day ___ (7 or earlier) **Date:___/___/_____**

Review Day ctd.

Provision of Advice

Lifestyle advice: **Smoking** **Diet**	**Relationship issues and contraception** **Driving**

Weight	Travel
Exercise	Employment and illness certification
Alcohol	Leaflets given and explained

Rehabilitation Goals and Actions

1

2

3

4

5

Other comments:

Name: Hospital Number:

Initial & date sections

Day 7 Date:___/___/_____

MDT Progress/Continuation Notes

Predictive date of discharge:

Divisional Senior Nurses (DSN's)

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

Divisional General Managers (DGM's)

Department	DGM	PA/Secretary
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Clinical Support Services (CSSD)	Steve Marper	Denise Hollies - 6709
Surgical	Felicity Greene	Alison Moore - 6287
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