Stroke Handover Document

The Stroke team is really lovely! It's a nice ward to work on and you are well supported by the consultants (always around in the office), reg Josh and trust grade F2 Junaid + other rotating doctors. The MDT involves the nursing staff, speech and language therapy (SALT) team, dieticians and physios + occupational therapists. You can ask for the SALT pack for junior doctors when starting which is very useful. The admissions side of things in A and E is run by the on-call consultant of the day and the stroke advanced clinical practitioners (ACPs).

P.s. if on shift with Abby, take it in turns to buy each other a chocolate bar, tis good vibes and I promised her I'd put this in here.

Access

If you need access to the ward then talk to Charlotte the ward manager in the office at the end of the corridor. If you have any problems with it you have to contact IT and book an appointment.

Usual Day

You usually start ward round at 9, worth getting in at 8:45 to prep the blue sheets if you know the patients, or 8:30 if you are seeing a new bunch of people and need to get to know them. Nothing particularly different, just worth knowing the scan results, when and how they initially presented, and if they are opening bowels / eating and drinking OK. You will usually be assigned 1-2 bays (there are 4 bays and 1 set of side rooms) for the week, to allow for continuity of care. Bay 4 is the hyper acute stroke unit (HASU) for new admissions and more unstable patients. Twice a week there are ward rounds for the outlier patients (usually the reg will go instead of you, but you may have to accompany occasionally).

You will finish ward around 11-12, and then have to go to board round every day at 12am with the MDT, where the team discusses what is happening with the patient and what type of discharge we can aim for (home independently, home with care, care home, fast track palliative). Helpfully there is no board round on Tuesdays so you can go to teaching.

You have the afternoon to do your jobs, and there is usually enough time to squeeze in teaching sessions if you like that kind of thing. Mostly you will be chasing and requesting scans, and referring to specialties on e-Referral (download Induction to get all the numbers, it's a lifesaver). You will be asked to calculate NIHSS scores every so often, so it is worth doing the e-learning online for this (just google it).

Patient's families often want an update as often things happen too fast to explain what has happened, worth showing them the scans and explaining to them how the stroke happened as this is frequently missed in the rush of thrombolysis. You will always get asked about recovery and physio, worth asking pts to direct these queries to PT/OT.

There is weekly radiology meeting on Wednesdays at 11am on Teams, and in person teaching on Thursdays at 1pm (which is usually very worth going to). Sarah Hunter (consultant ACP) runs the teaching schedule so if you would like to present a paper / topic she will be happy to add you to the rota. There is currently an OPTIMAS trial running on the ward, worth talking to Dr Kong if you want to get involved with recruiting patients (is not too much work).

Palliative Patients

If patients are on EOL care, you need to use a yellow EOL ward round sheet instead, and using the yellow palliative medication booklet to prescribe all the pre-emptives. Sadly stroke is not on EPMA yet so tis all handwritten :(

On-Calls

Whilst on stroke you are under the acute medical rota as well, so have on-calls once every 6 weeks. These include twilight shifts (16:00 - 00:00) and day shifts (9-21:30) which can be pretty draining, but are useful for learning (lots of clerking of acute patients). ED can be fairly overwhelming initially as there is no real induction. For Day FY1 shifts you meet in the MEAU A side handover room (the one closest to stroke) for handover at 9am, and need to write down any sick patients / jobs mentioned in ED as that will likely be your job list. You can also be pooled to MEAU (basically just ward jobs with sicker patients) or discharge summaries, but this happens quite rarely. For twilight shifts go directly to ED and talk to the med reg to ask what they want you to do (usually clerking).
In ED you will normally have a list of jobs to get through before clerking. When you start clerking, grab the ED notes from waiting room / wherever the patient is, and make sure you look at the past admissions on CarePortal (under web applications on Edge). Write the drug chart up from the summary care record as it tends to be more up to date. Be sure to fill out everything (confusion screen, coagulation risk chart etc.) as if you don't people will be grumpy haha. Also worth remembering that when ordering scans in ED, you have to vet anything that isn't a CT head or x-ray with the on-call radiologist (call them through switchboard). You also have to write the scan and name of the patient down on the porter's list if you want the porters to take them to the scanner (if mobile then tell them to walk to the waiting room). Once you have clerked a patient on your own, you then need to see them with the on-call consultant and fill in the consultant review. If you are on twilights, there are often no consultants around so check your plan with med reg. You usually work with the same team which is helpful :)
You have discharge shifts which are basically 9-5 in the discharge lounge (down the corridor from stroke). These are usually pretty chilled, so bring something to do. However, you might occasionally get pooled to ED/MEAU.

<u>Hyper Acute Stroke Unit (HASU)</u>
Bay 4 is the hyperacute stroke unit, which handles new admissions. The ward round theoretically starts at 8am, although realistically at 8:30-8:45. There is a new consultant 'on-call' every day. Your job is to handle the jobs in the ward, which varies between very chilled to extremely busy. You are under no obligation to turn up at 8 - I did for my first couple of weeks, and in theory you can then leave at 4pm. In practice you will usually stay until 5 for no extra pay (you could probably exception report?), so be warned. If the ward is stable, you can go to A and E with the ACPs and on-call consultant, which is really useful learning / quite fun if you want to see acute neurology or get portfolio sign-offs.

<u>Discharge Summaries</u>

Stroke discharge summaries are slightly different and should be written with the below formula:

1. Presenting symptoms and clerking findings
2. Imaging and ECG results on admission
3. Risk factors: HbA1c, cholesterol/lipids, BP, alcohol and smoking intake (and how each of these have been controlled)
4. Drugs - worth checking if they are on aspirin/clop +/- gastroprotection because this might need changing in the community
5. Neurological status on leaving - ideally NIHSS and mRS score, but also examination findings
6. MDT input: physio, OT and diet/SLT recommendations (there is a section on discharge summaries to add diet/SLT recs, the info can be found on the patient's whiteboard above their bed. If they need thickened fluids you need to prescribe thickener, liaise with SALT/Junaid to see exactly what)

7. Driving rules (v important!)
8. Follow up - usually stroke follow up appointment in 6-8 weeks, and if they have not had AF on admission you need to book tests on d/c to look for this (usually outpatient echo and 72 hour tape, bubble echo instead if they are young). Worth asking GP to monitor BP / electrolytes / LFTs etc. if they have started lots of new drugs.

Leave

Worth checking with the others when taking leave to make sure the ward is not understaffed. Usually there is not much of an issue as we are quite well staffed after a bit of a staff crisis in July. I have always found going in person to meet Lindsay Stuffins in business unit (near d/c lounge) is much better than emailing, as she is lovely + you can have a chat and get it approved then and there.