



The Leeds Acute Stroke Care Pathway

WQN143

Patient's Name

Patient's Address

..... Postcode

Date of Birth..... Age

Hospital No..... M/F

Date

Time.....

Source of History

.....

.....

.....

Presenting History: If patient unable to give a history, look for alternative source, e.g.; telephone relatives or GP.

Right / Left Handed

R L

Date/Time of onset of symptoms:

.....

Driver

Yes No

Medical Problem List

To be completed by medical staff within 24 hours of admission

Date	Active	Inactive

Known Risk factors

Brief details or state if not known:

Previous Stroke

Yes No

.....

TIA's

Yes No

.....

Hypertension

Yes No

.....

Ischaemic Heart Disease

Yes No

.....

Other cardiac disease, e.g., AF

Yes No

.....

Peripheral Vascular Disease

Yes No

.....

Diabetes

Yes No

.....

Hyperlipidaemia

Yes No

.....

Smoking

Ex Current Never

.....

Alcohol _____ units per week (*1 unit = 1/2 pint beer/single glass of wine/single measure of spirits*)

If information is unavailable, please arrange for someone to telephone the GP.

Pre-Stroke Function

	Yes Normal	Help	No Abnormal
Can DRIVE CAR?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can USE BUS or TAXI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can SHOP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can COOK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can do LAUNDRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can MANAGE FINANCES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BASIC ADLs

	Yes	Help	No
Can WALK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can TRANSFER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can MANAGE STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can BATH (or shower)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can DRESS SELF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can GROOM SELF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can manage to use TOILET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	Help	No
Is CONTINENT of URINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is CONTINENT of FAECES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rankin Scale or Oxford Handicap Scale

Pre-stroke score

0 = Well, no symptoms

1 = Minor symptoms NOT affecting lifestyle

2 = Minor handicap but independent in self care

3 = Moderate handicap - help with ADLs needed

4 = Needs lots of help with ADLs

5 = Needs constant attention day and night

Leisure Activities

Social History

Occupation (*Please mention ALL jobs*)

Retired Married Widowed Single Divorced

Religion..... First language

Who do you live with?..... No-one

Who is main carer?.....

Has carer any health problems?.....

Next of kin (*if different*)

Adaptations:.....

Aids:.....

Description of Home

Type:

Detached Semi-detached Flat (*If so, which floor.....*)

Stairs: Yes No

Residential Home Nursing Home

Council owned Rented Relative owned Self owned

Examination

Nutritional state (*overall impression*) Weight.....

Skin / Nails.....

Dentures.....

Hearing (*if abnormal aid?, wax?*).....

Eyesight (*glasses?*).....

Cardiovascular.....

Pulse..... Rate..... Rhythm.....

BP:..... **L**..... **R**.....

JVP.....

Heart Sounds.....

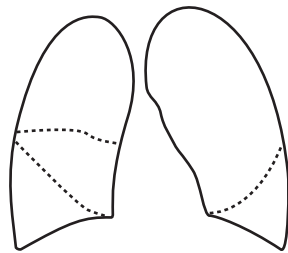
Peripheral Oedema? Yes No

Neck Bruit? Yes No

Temporal arteries pulsatile Yes No Tender Yes No

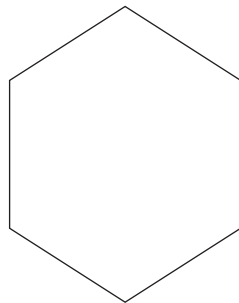
If no, which pulses? Yes No

Chest



.....
.....
.....
.....

Abdomen



Is there an abdominal aneurysm:

Yes No

.....
.....
.....

Locomotor:.....

Neurological assessment (*tick appropriate box*)

Glasgow Coma Scale

Eye Opening

- 1 Never
- 2 To pain
- 3 To sound
- 4 Spontaneously

Best Motor

- 1 None
- 2 Extend to pain
- 3 Abn flex to pain
- 4 Flex to pain
- 5 Localises to pain
- 6 Normal

Best verbal

- 1 None
- 2 Noises only
- 3 Inappropriate
- 4 Confused
- 5 Normal

Total

Communication Difficulty

- No Mild Moderate Severe
 Dysphasia Dysarthria Untestable/Uncertain Mute

If dysphasia - are reading and writing affected:

.....
.....

Mental Test Score (*Hodkinson*)

- | | | | |
|---------------------------------------|--------------------------|-----------------------|--------------------------|
| Age | <input type="checkbox"/> | Year | <input type="checkbox"/> |
| Time (<i>nearest hour</i>) | <input type="checkbox"/> | Recognise 2 people | <input type="checkbox"/> |
| 42 West Street | <input type="checkbox"/> | Date of birth | <input type="checkbox"/> |
| <i>(ask patient to recall at end)</i> | | | |
| Name of hospital | <input type="checkbox"/> | Dates of World War II | <input type="checkbox"/> |
| Present Monarch | <input type="checkbox"/> | Count down 20-1 | <input type="checkbox"/> |
| Total | <input type="text"/> | | |

If unable to complete give reason:.....
.....

Nb - no half marks, must be fully correct for mark

Swallowing

Can patient swallow safely? Yes No



To test swallowing:

Explain the procedure to the patient, ensure patient is sat upright, is well supported and alert.

If patient coughs or voice sounds 'wet', patient is unsafe and kept nil by mouth with subcutaneous or I V fluids - see swallowing algorithm.

If patient is unable to sit and is drowsy then consider unsafe - see swallowing algorithm.

Cranial Nerves (*If not possible to test record reason*)

	R	L	R	L
Visual Acuity (<i>corrected</i>)			Facial Sensation (V)	
Pupil Reactions (<i>light</i>) (<i>accommodation</i>)			Facial Movement (VII)	
Ptosis			Hearing (VIII)	
Fundi			Palatal Sensation (IX)	
Visual Fields			Palatal Movement (X)	
Visual Inattention			Cough (X)	
Eye movements (III/IV/VI)			Sternomastoids (XI)	
			Tongue (XII)	

Arms	R	L	Legs	R	L
1. Tone			1. Tone		
2. Power (MRC)			2. Power (MRC)		
Shoulder			Hip		
Elbow			Knee		
Wrist			Ankle		
Hand					
Drift					
Fine finger movement					
3. Co-ordination (finger/nose)			3. Co-ordination (heel/shin)		

Sensory Testing Pinprick or light touch and joint position sense.
(If not possible to test give a reason.)

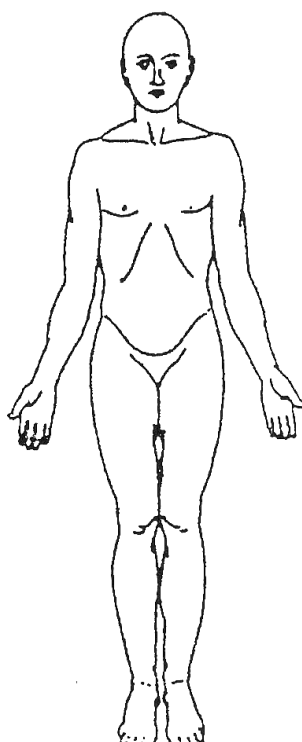
Is there any sensory loss? Yes No
(If yes record on body schema)

Is there sensory inattention Yes No If yes, right or left?

Indicate Reflexes on body schema

0 = absent, 1 = diminished, 2 = normal, 3 = increased, c = clonus

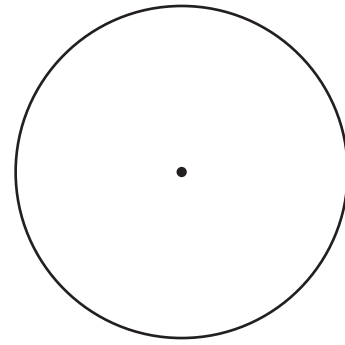
	R	L	R	L
Jaw Jerk				
Triceps (C7,8)				
Biceps (C5,6)				
Sup (C5,6)				
KJ (L3,4)				
AJ (S1,2)				
Plantar				



Visuospatial (e.g. neglect or sensory inattention)

Please draw in the numbers on this clock face

Is there evidence of visuospatial dysfunction? Yes No



If it is not possible to test, record reason.
Sometimes neglect is obvious from observing the patient.

Gait

Normal Ataxic Hemiparetic Unable to stand
Other

Describe:
.....
.....

Summary

(include stroke side, sub type, aetiology, risk factors)

Investigations

Level 1 Perform in all patients **immediately** and fill in result.

Hb	<input type="checkbox"/>	Na	<input type="checkbox"/>	Albumin	<input type="checkbox"/>
WCC	<input type="checkbox"/>	K	<input type="checkbox"/>	Urinalysis	<input type="checkbox"/>
Platelets	<input type="checkbox"/>	Urea	<input type="checkbox"/>	ECG	<input type="checkbox"/>
PV	<input type="checkbox"/>	Random	<input type="checkbox"/>		
Cholesterol	<input type="checkbox"/>	Glucose			
		Fasting	<input type="checkbox"/>		

CT Scan

Date requested:

Results:.....
.....

Level 2 Perform in **selected** patients only

Requested

Result

VDRL/TPHA

Chest x-ray

Carotid Doppler

Cardiac Echo

24 hour tape

Level 3

Perform only if no clear aetiological explanation apparent after discussion with consultant

Vasculitis screen

Thrombophilia screen

MR Studies

Other (*list*)

Management Plan

Problems and proposed action:

Admit to Stroke Unit: Yes No

(If No, please comment why)

Consider inclusion in research studies

Doctor's Details

Doctor's name:..... Grade:

Signature: Bleep No:

Date:

If you have been unable to complete parts of this form please fill them in later, *(signed and dated)*.

Investigations

Level 1a and 1b (Admission)

Day 1

Level 1 tests completed and **results recorded**

Yes No

If **No**, why not?
.....
.....
.....

Signed: Date:.....

Aspirin for infarcts**

Yes No

If **No**, why not?
.....
.....
.....

Signed: Date:.....

Day 2

(If no CT by 24 hours arrange + review immediately)

If not done, why not?
.....
.....
.....

Aspirin for infarcts**

Yes No

If **No**, why not?
.....
.....
.....

Signed: Date:.....

** Aspirin can be given before CT result is known if risk of cerebral bleed is low. Clinical features pointing towards bleed are: early fall in GCS, eye deviation, vomiting, severe headaches.

Audit Standards

Standard	Responsibility for signing off	Standard achieved (Yes or No)	If 'No', why not?	Signature
Brain scan within 24 hours	Admitting Doctor			
Conscious level documented within 24 hours	Admitting Doctor			
Eye movements recorded within 24 hours	Admitting Doctor			
Visual field assessment within 24 hours	Admitting Doctor			
Formal sensory testing within 24 hours	Admitting Doctor			
Clear diagnostic description made within 24 hours	Admitting Doctor			
Aspirin commenced within 48 hours	Admitting Doctor			
Sip test performed within 24 hours	Sip trained staff			
Swallow assessment by speech and language therapist within 72 hours	SALT			
Physiotherapy assessment within 72 hours	PT			
Assessment of communication problems by speech and language therapist within 7 days	SALT			
Occupational therapy assessment within 7 days	OT			

Nursing Interventions

Complication Prevention

Day 1 (Admission)

TED	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Sitting out	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Hydration Adequate	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- action taken
Referred to SALT if speech deficit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Signed:		Date:.....	

Day 2

TED	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Sitting out	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Hydration Adequate	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- action taken
Referred to SALT if speech deficit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Signed:		Date:.....	

Day 3

TED	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Sitting out	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not (<i>must see physio by Day 3</i>)
Hydration Adequate	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- action taken
Referred to SALT if speech deficit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Signed:		Date:.....	

Day 4

TED	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Sitting out	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Hydration Adequate	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- action taken
Referred to SALT if speech deficit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Signed:		Date:.....	

Day 5

TED	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Sitting out	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Hydration Adequate	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- action taken
Referred to SALT if speech deficit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	- why not
Signed:		Date:.....	

Nursing Observations

Monitoring (Contact medical staff if: O₂ saturations <93% on air, temp>37, glucose < 3 > 11 or BP <100 or >200 systolic.)

Day 1 (Admission)

				why not
BP	continuous	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O ₂ Saturation	continuous	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Temperature	continuous	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glucose	4 hourly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signed:		Date:.....		

Day 2

				why not
BP	continuous	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O ₂ Saturation	continuous	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Temperature	continuous	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glucose	4 hourly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signed:		Date:.....		

Day 3

				why not
BP	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O ₂ Saturation	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Temperature	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signed:		Date:.....		

Day 4

				why not
BP	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O ₂ Saturation	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Temperature	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signed:		Date:.....		

Day 5

				why not
BP	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
O ₂ Saturation	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Temperature	twice daily	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signed:		Date:.....		

Nil by mouth patients *(Please refer to dysphagia detection and management protocol.)*

Day 1 (Admission)

Have IV or SC N Saline been prescribed and given?

Yes No Comment:

Signed: Date:.....

Have essential drugs been given parenterally?

Yes No Comment:

Signed: Date:.....

Have corsodyl and artificial saliva been prescribed and given 4 hourly?

Yes No Comment:

Signed: Date:.....

Day 2

Have IV or SC N Saline fluids been prescribed and given?

Yes No Comment:

Signed: Date:.....

Have essential drugs been given parenterally?

Yes No Comment:

Signed: Date:.....

Have corsodyl and artificial saliva been prescribed and given 4 hourly?

Yes No Comment:

Signed: Date:.....

Day 3

Have IV or SC N Saline been prescribed and given?

Yes No Comment:

Signed: Date:.....

Have essential drugs been given parenterally?

Yes No Comment:

Signed: Date:.....

Have corsodyl and artificial saliva been prescribed and given 4 hourly?

Yes No Comment:

Signed: Date:.....

Has NGT been inserted and position checked in CXR?

Yes No Comment:

Signed: Date:.....

Continence Promotion

Day 1 or any day patient develops incontinence

Did patient suffer with incontinence before admission?

Yes No

If **yes**, detail:
.....
.....

Have buzzer and toileting options been explained to patient, e.g. bottle, commode, toilet, convene, etc.?

Yes No

Comment:
.....
.....

Signed: Date:.....

Has the need for regular toileting been assessed?

Yes No

Comment:
.....
.....

Signed: Date:.....

Has the need for a catheter been assessed?

Yes No

Comment:
.....
.....

Signed: Date:.....

Comment:

Has doctor/nurse taken GU history? Yes No

Doctor examined abdomen (*done PR*)? Yes No

TTU been taken? Yes No

Bladder scan been performed? Yes No

Continence chart been started? Yes No

Skin assessed? Yes No

Have the options been assessed? Yes No

Bottles 1-2° Yes No

Sheath Yes No

Pants Yes No

Catheter Yes No

Communication/Information (all by Day 5)

1.) Diagnosis and tests

Yes No

Details of advice given:

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Signed: Date:.....

2.) Risk factor modification

Yes No

Details of advice given:

.....

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.....

.....

.....

.....

Signed: Date:.....

3.) Driving advice given

Yes No Not Driver

Signed: Date:.....

4.) Ward stroke information pack given to patient and/or carers

Yes No N/A

(Why?)

.....

Signed: Date:.....

Any other advice given?

.....

.....

.....

.....

Occupational Therapy (All patients must be seen in first week after admission.)

Date of initial contact:

Occupational Therapy required? Yes No

If **No**, please state reason:
.....
.....

If **Yes**, what is the initial OT plan?

Physical Assessment Yes No

Comment:
.....

Perceptual Screen Yes No

Comment:
.....

Cognitive Screen Yes No

Comment:
.....

Personal ADL Assessment Yes No

Comment:
.....

Domestic ADL Assessment Yes No

Comment:
.....

Feeding Assessment Yes No

Comment:
.....

Functional Mobility/Transfers Yes No

Comment:
.....

Seating Issues Yes No

Comment:
.....

Other:
.....
.....

Name of Occupational Therapist: Contact No:

Physiotherapy (All patients **must** be seen and assessed within 72 hours of admission.)

Initiated assessment <72 hrs Yes No

Moving and handling Yes No

Respiratory assessment Yes No

Seating assessment Yes No

Summary of action:
.....
.....

Signed: Date:

