South London
Cardiac and Stroke Network

HIGH LEVEL GUIDELINES FOR PATIENTS ACCESSING STROKE SERVICES IN SOUTH LONDON

Version 1.4

Document review	Version	Comment	Initials
December 2011	1		EJH
January 2012	1.1	Updates to contact details	EJH
March 2012	1.2	Updates to guidance for overseas visitors and patients with no fixed abode	EJH
May 2012	1.3	Updates to referrals to community diagrams	EJH
April 2013	1.4	Updates to contact details	VB

South London Cardiac and Stroke Network

April 2013

Table of contents

PROTOCOL FOR MANAGING POSSIBLE STROKE PATIENTS PRESENTING AT A NON-HASU ED OR URGENT CARE CENTRE

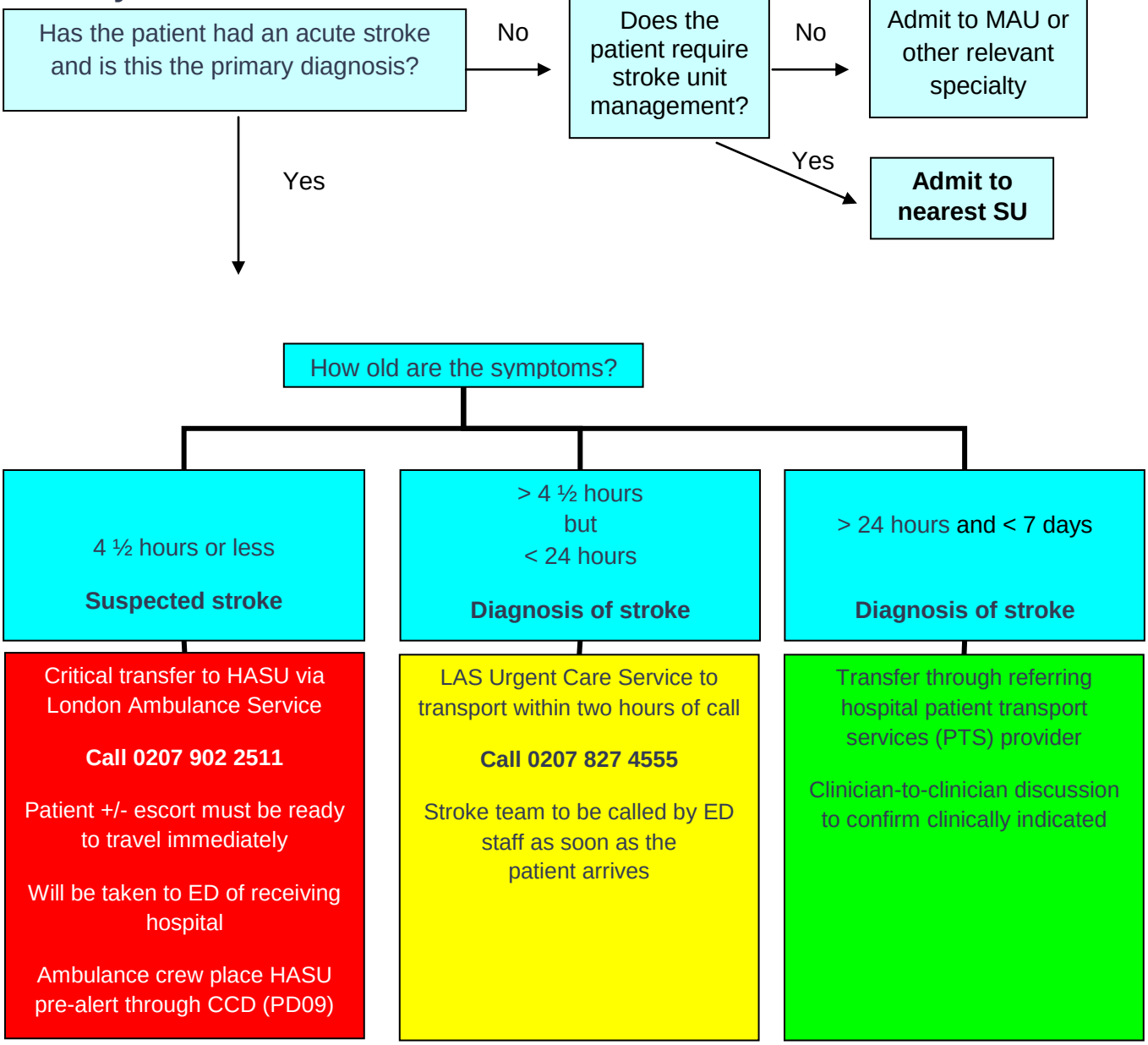
All FAST-positive patients outside hospital or at presentation to an Emergency Department (ED), either as a self-presenter or by London Ambulance Service (LAS), will be taken directly to a Hyper Acute Stroke Unit (HASU), bypassing local emergency departments.

If a patient presents at an ED of a multi-sited Trust with a HASU, the Trust should have an internal mechanism to ensure that the patient is directly admitted to the Trust's HASU.

The priority is to transfer FAST-positive patients to a HASU with the minimum of delay, as per the pathway below. (For more detailed information see *LAS ED to HASU transfer policy*).

Note: Neuroimaging should **not** be performed locally as this will delay transfer.

Pathway



PROTOCOL FOR MANAGING IN-PATIENT STROKES (INCLUDING PRE-OPERATIVE STROKE)

Peri-procedural acute stroke

If the main problem is stroke, there should be an urgent clinician-to-clinician discussion regarding referral to the nearest HASU and consideration whether the patient is suitable for thrombolysis.

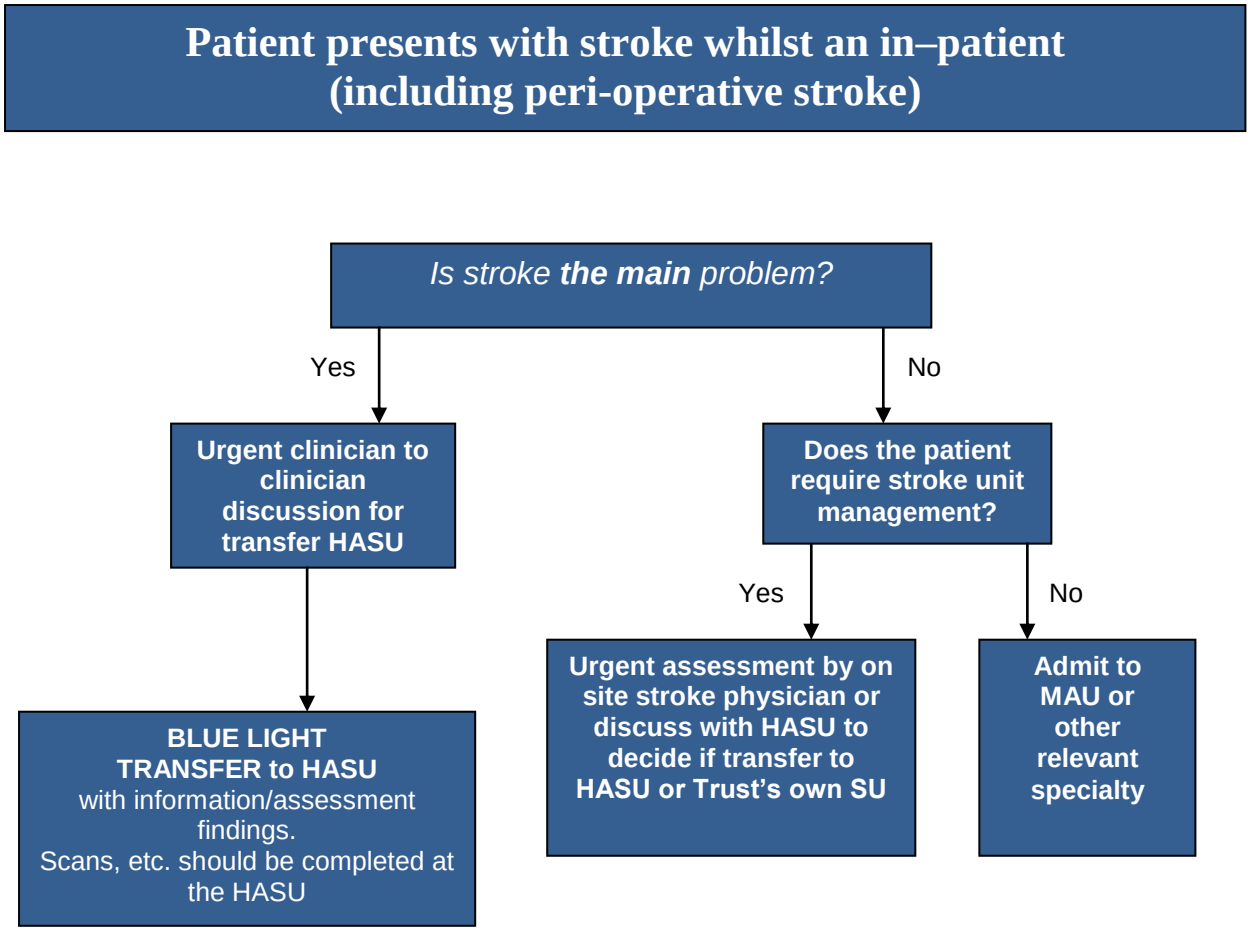
Acute in-hospital strokes

Strokes occurring in hospital on patients with other significant acute conditions (e.g. those on intensive care unit [ICU] or intensive treatment unit [ITU]) or with post-operative complications) require consideration on an individual basis by the local acute stroke physician/neurologist or HASU on-call team.

Patients may be considered for transfer to either HASU or SU, based on clinical need. It is recognised that such patients are likely to need dual specialty input to their care. This needs to be considered in any inter-hospital transfer.

In-hospital stroke > 24 hours

If the patient is found with stroke symptoms greater than 24 hours following suspected episode, there should be a same-day assessment by an on-site stroke physician wherever possible. If there is no on-site stroke physician, there should be a discussion with the nearest HASU to decide whether to send that patient to the HASU, local SU or to remain under the admitting team with specialist advice.

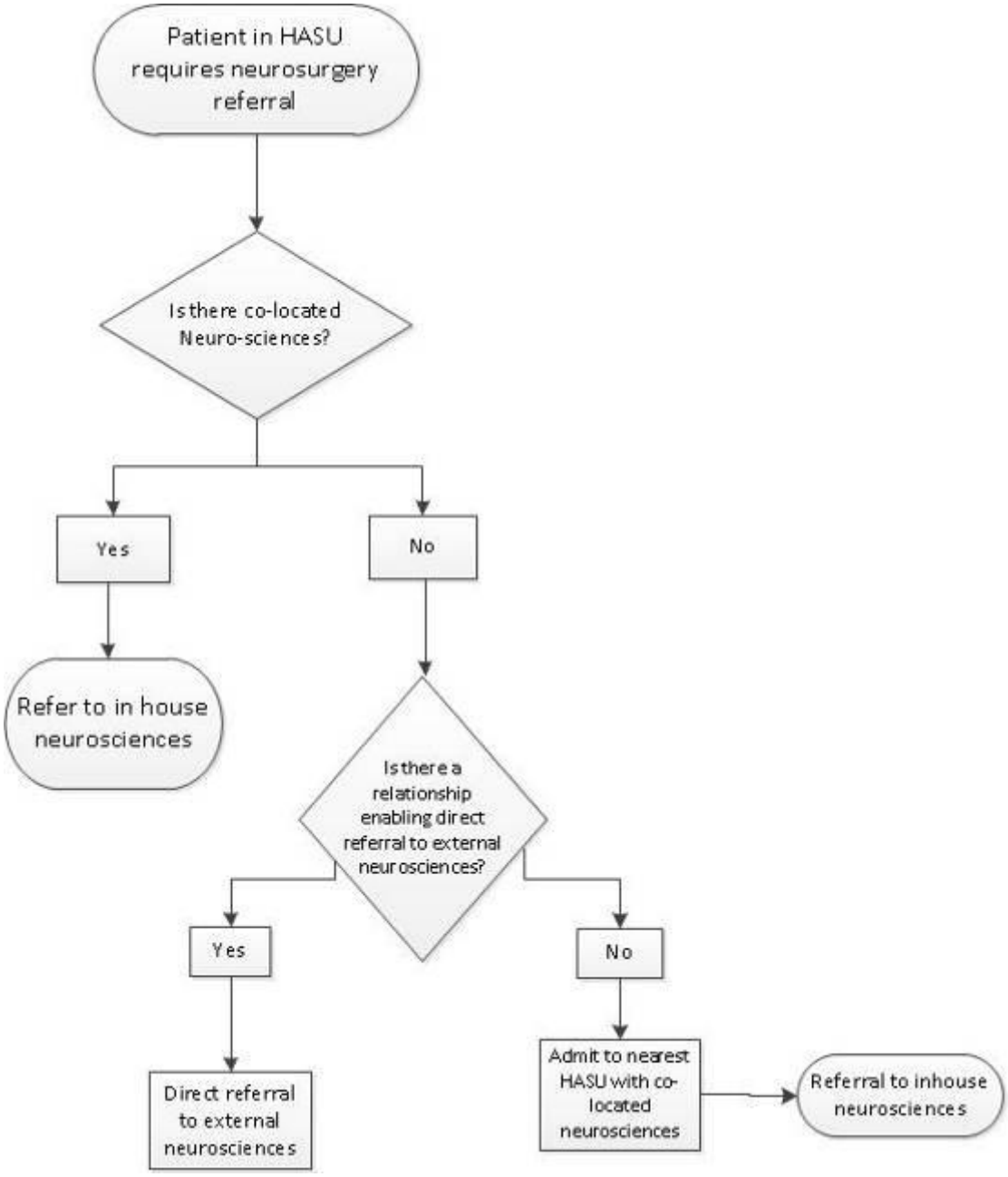


PROTOCOL FOR NEUROSURGERY REFERRALS

HASUs without a co-located neurosciences centre should either refer directly to an external neurosciences centre or to the nearest HASU with a co-located neurosciences centre.

London neuroscience centres include: St George's Hospital, King's College Hospital, The Royal London Hospital and UCL Institute of Neurology, Queen Square.

Guidelines



HASU GUIDANCE FOR REFERRING SPONTANEOUS INTRACRANIAL HAEMORRHAGES TO A NEUROSURGEON

Patients with spontaneous intracranial haemorrhages must be treated in a HASU or neuro high dependency unit (HDU)/ICU, according to clinical need.

Cerebellar haemorrhage

This can be a neurosurgical emergency. Alert a neurosurgeon immediately. Especially if:

- The patient has signs of a brainstem syndrome (e.g. dysarthria, diplopia, etc.)
- There is progressive neurological deterioration, including agitation
- There is evidence of hydrocephalus on CT
- There is brainstem compression on CT
- The tectal cisterns are obliterated on CT (risk of brain stem compression)

Supratentorial haemorrhage

The Surgical Treatment for Ischemic Heart Failure (STICH) Trial showed no clear evidence for routine **immediate** surgical evacuation of all spontaneous supratentorial intracerebral haemorrhages. However, sub-group analysis of the STICH trial suggests that there **may** be benefit in surgical evacuation of a superficial cortical haemorrhage in selected cases. STICH II aims to evaluate this problem. Protocols may be reviewed as more data becomes available.

A patient with an impaired level of consciousness and intracerebral haemorrhage should ALWAYS be discussed with the neurosurgeons (unless deemed clearly unsuitable for any surgical intervention by the referring team).

Deep supratentorial haemorrhage

This is **rarely** an indication for surgery. An **urgent discussion** with a neurosurgeon should occur in the case of:

- Progressive neurologic deterioration
- Hydrocephalus
- Appearance on plain CT suggesting structural underlying cause (see callout)

Lobar supratentorial haemorrhage

A few **selected cases** may be considered for surgery. Discussions with a neurosurgeon should occur on an individual patient basis.

Needs **urgent** discussion with neurosurgeons in case of:

- Progressive **neurologic deterioration**
- Hydrocephalus
- Appearance on plain CT suggesting structural underlying cause (see callout)

Signs on CT scan which suggest an underlying structural lesion

- Subarachnoid component of the haemorrhage
- IVH
- Abnormal calcification
- Prominent vascular structures
- Site of haemorrhage (eg in temporal lobe or close to Sylvian fissure

Surgery would **NOT** normally be considered in the case of:

- Mild neuro deficits
- Small volume supratentorial haemorrhage
- Brain stem haemorrhage
- Pupils fixed and dilated
- GCS ≤ 4 (except in case of cerebellar haemorrhage, when surgery is still considered)

Subarachnoid and intraventricular haemorrhages (IVH)

All subarachnoid haemorrhages should be referred to neurosurgery.

Intraventricular haemorrhages should be referred immediately, in case of hydrocephalus or an underlying aneurysm or arteriovenous malformation (AVM) as cause of IVH.

PROTOCOLS FOR DECOMPRESSIVE HEMICRANIECTOMY FOR MALIGNANT MCA INFARCTION: *ST GEORGE'S HOSPITAL*

HYPERACUTE STROKE UNIT HEMICRANIECTOMY GUIDELINES

Hemicraniectomy

This is an emergency neurosurgical operation. Patients with a large middle cerebral artery (MCA) infarct are at high risk of developing severe brain swelling and death from coning, the malignant MCA syndrome. A little, high quality data is available (mainly 93 patients from three studies) to inform a decision on referral for neurosurgery. (NNT is number needed to treat. mRS is the modified Rankin Score. NIHSS is the National Institutes for Health Stroke Scale.)

- Survival in any condition: NNT is TWO patients
- Survival with mRS≤3: NNT is FOUR patients
- The outcome in patients over the age of 50 appears very poor.
- Dominant hemisphere infarction is **NOT** a bar to surgery.
- Treatment with thrombolysis is **NOT** a bar to surgery.

REFERRAL CRITERIA

Inclusion

Patients with MCA infarction who meet all of the criteria below should be considered for decompressive Hemicraniectomy. They should be referred within 24 hours of onset of symptoms, the intention being to treat within a maximum of 48 hours.

- Age up to 60 years (NICE guidance)
- Within 48 hrs of stroke onset
- Total NIHSS score >15
- Drowsy. (NIHSS item 1a should score ≥1)
- Imaging evidence of >50% MCA territory infarction with or without additional infarction in the territory of the ipsilateral anterior or posterior cerebral artery.

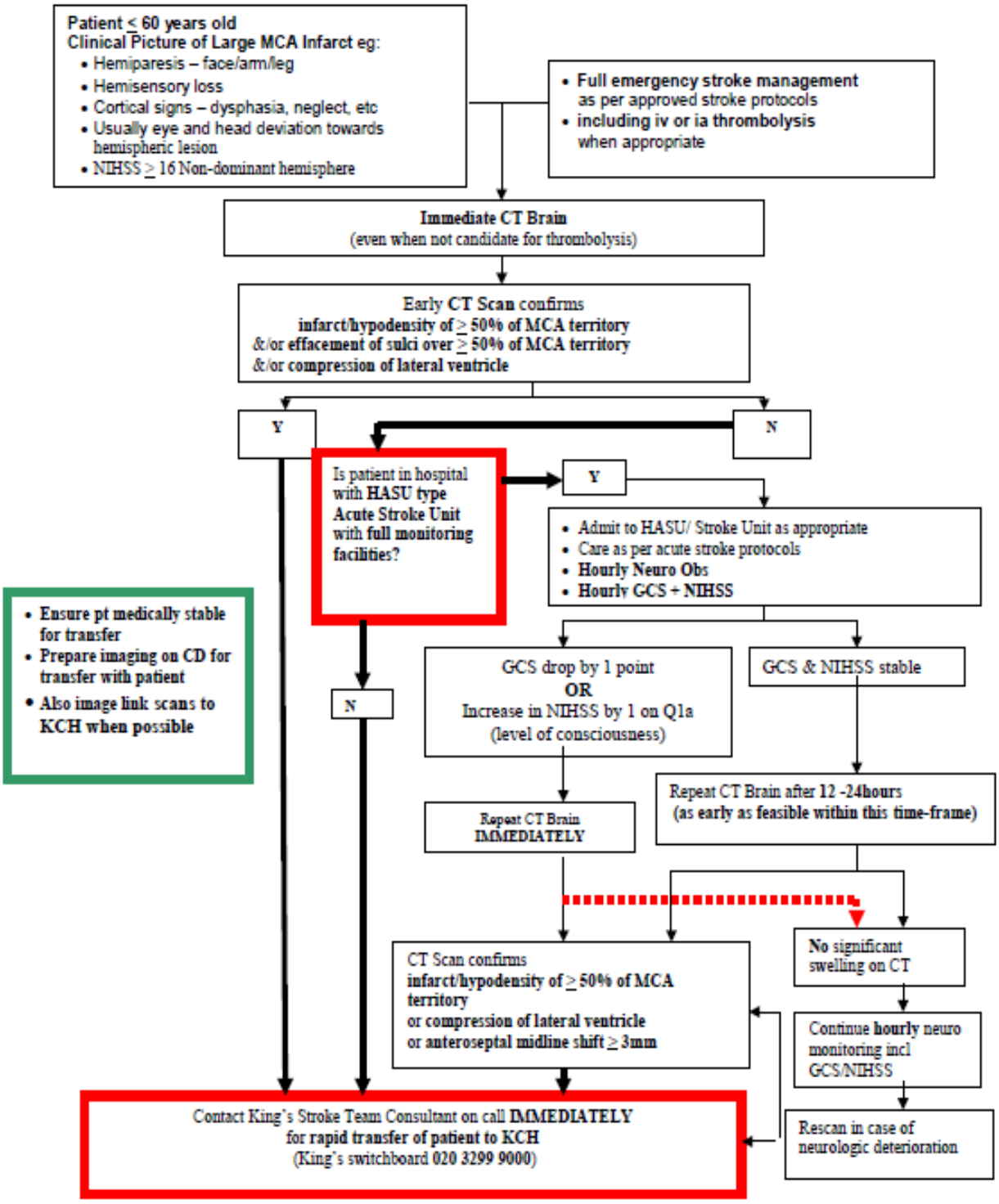
Exclusion

- Short life expectancy (<3 years).
- Pre-existing disability (pre-morbid mRS ≥2)
- Two fixed dilated pupils
- Major medical or neurological co-morbidity (that may worsen outcome).

REFERRAL PROCESS

- Referrals should be made to the stroke registrar holding the thrombolysis bleep (7317).
- Patients should be transferred to the HASU, William Drummond ward.
- Patients and their families will be counselled by the stroke team prior to referral for neurosurgery
- After surgery, patients will go to NITU under the care of the neurosurgeons
- From NITU, patients will return to the HASU under the care of the stroke team.
- Patients will then be transferred back to the referring hospital. Note, patients will only be accepted from a referring hospital on the understanding that the referring hospital accepts their transfer back once perioperative care has been completed.
- A separate short admission will be pre-arranged for cranioplasty in 3 months.

PROTOCOLS FOR DECOMPRESSIVE HEMICRANIECTOMY FOR MALIGNANT MCA INFARCTION: *KING'S COLLEGE HOSPITAL*

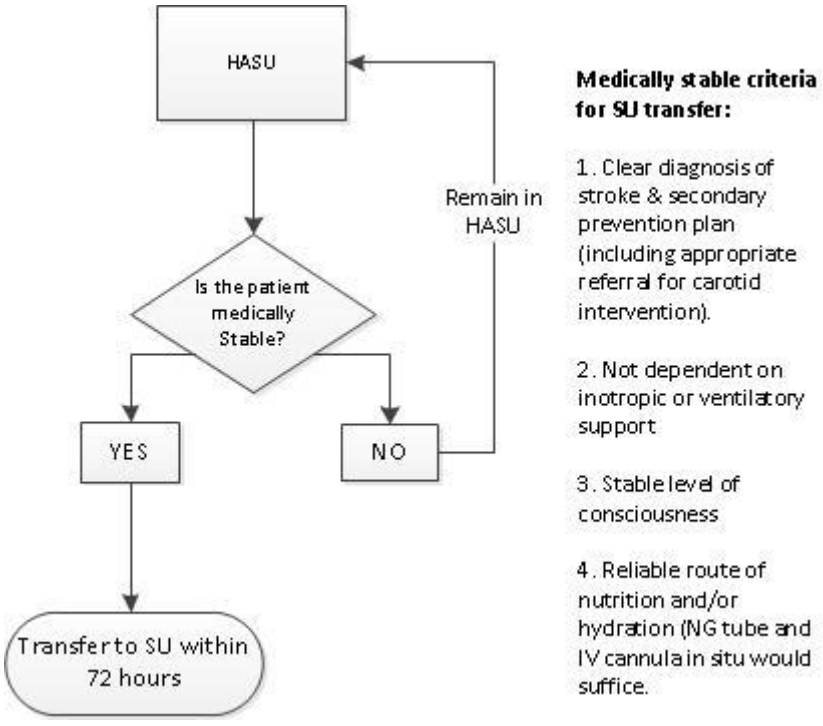


HASU TO SU TRANSFERS

Protocol for transfer from HASU to SU

- All medically fit patients should be repatriated to an SU within 72 hours or earlier, as appropriate.
- There should be an efficient operational policy agreed, including an escalation policy (see Appendix 1 – *Escalation process for delayed transfers to SU*). Ideally, patients should be transferred from the HASU to the patient's local SU. If it is not possible to transfer patients to the local SU within the specified timeframe due to lack of SU capacity, this should be escalated to senior management and transfer to an alternative SU should be considered.
- There should be clinician-to-clinician communication to agree the transfer and confirm patient is "medically stable"; a discharge summary should be sent and access to scans provided.
- Patients should be transferred to the local SU within daylight hours wherever possible.
- Repatriation should take place seven days a week.

Guidelines for protocol for HASU to SU transfer



Transfer of stroke patients from HASU to SU pathway

- Identify appropriate SU from stroke look up **www.londonsulookup.nhs.uk**
- Patient details added to notification sheet (see Appendix 3 - Stroke patient notification sheet), sent daily by NHS.net email/fax to all SUs

Within 24 hours of admission

Clinical assessment
Patient assessed for suitability to transfer

Within 24 hours of admission and on-going during HASU stay

Medical assessment
On-going patient's care team assess patients to confirm medically stable of discharge

Nursing assessment
Lead nurse for stroke completes transfer form

Therapy assessment
Individual therapist complete treatments records in patients medical notes

Referral to SU and agreement between HASU and SU of date fit for transfer

Patient should be repatriated to the relevant SU within 24 hours of referral date/date fit for transfer. All details added to daily stroke notification sheet

Stroke coordinator/navigator

Call SU to confirm receipt and request a bed

Details of any contact added to notification sheet

Host trust confirms arrangements in place to accept transfer

(see Appendix 1 - Escalation process for delayed transfers to SU if SU unable to accept patient)

Book transport

Medical referral
Differs at each HASU
See table, *HASU to SU transfer of information* (next page)

Patients/carers should be provided with written information regarding the London acute stroke model, repatriation and choice. Where HASUs do not have their own versions, they can download the London Stroke Networks' aphasia-friendly booklet from the website. *(To be available January 2012)*

HASU to SU transfer of information

	HASU	SGH	King's	PRU
Notification	**Who completes**	Stroke navigator	Stroke navigator	Nurse
	How sent	Daily fax / email to SUs	Daily e-fax	Daily email
	What information included	See Appendix 3 – South London stroke notification sheet		
Referral	**Who completes**	Consultant or trainee		Stroke SHO
	How sent	E-fax / email Ward clerk weekdays Nurse in charge weekends	E-fax	Included in the patient's medical notes (verbal referral as well, if specific medical issues)
	What information included	Discharge summary	Referral letter	Referral letter
Information sent with patients	**Who completes**	Nurse	CDs	Nurse
	How sent	With patient		With patient
	What information included	See Appendix 5 – SGH transfer document	See Appendix 4 – KCH transfer sheet	See Appendix 6 – PRU transfer sheet

HASU to SU: Contact details for transfer

The London Stroke Unit Lookup tool maintains up-to-date contact details for each SU, www.londonsulookup.nhs.uk.

Each unit should ensure the details are current. Amendments can be made via the Network or by emailing the administrator at info@slcsn.nhs.uk. Details will be changed within two working days of the request.

Overseas visitors

Patients who live outside the UK requiring further SU care before repatriation will be managed in one of the cluster's SUs. The pan-London Clinical Advisory Group agreed where a local link can be

established for these patients that a detailed consultant-to-consultant discussion occur between the HASU and SU in order to provide transparency of all relevant information.

Where agreement cannot be reached between clinical teams, the matter should be passed to Trust bed managers or overseas officers, where applicable, to resolve.

Patients with no fixed abode

Every effort should be made to establish an address of usual residence. If a patient is unable to give an address and they are not registered with a GP practice, the host Trust should be determined by the terms of 'usual residence'. If patients consider themselves to be resident at an address, which is for example a hostel, then this should be accepted.

'Usually resident' is largely determined by the person's own perception of where they are resident (either currently, or failing that, most recently) as evidenced by the address they give. If a person is unable to give an address, and their place of residence cannot be established by any other means, the responsible commissioner is the PCT in whose area the unit providing treatment is located.[1]

When dealing with social services, the term is 'ordinary residence', but the same basic rules apply, where a person is not ordinarily resident in any local authority (a person of "no settled residence"), the NHS Trust should notify the local authority in which the hospital is situated.[2]

The network will collect the contact details of each Trust's homeless discharge coordinator and share this.

Mixed accommodation guidance

The NHS Operating Framework for 2011-2012 confirmed that all providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient.

Information on mixed sex accommodation is available on the Department of Health website.

Infection control guidance

No patient should knowingly be transferred with contagious infectious illness (such as norovirus) without clinician-to-clinician discussion and appropriate infection control measures. However, this should not prevent timely repatriation outside of the context of a patient being in a clinically unstable condition.

It is accepted that on occasion, in such circumstances patients may not be repatriated direct to a Stroke Unit (AMU if mimic) in order to meet the infection control requirements and maintain patient safety.

As soon as the period of infectious illness has passed - provided stroke is the predominant medical problem – such patients should be transferred to complete their inpatient stay on a Stroke Unit.

General contracting rules for HASUs

"Stroke units must accept a patient from a HASU for which they are the defined stroke unit as per the Healthcare for London mapping table. HASUs have the authority to repatriate patients to the

[1] *Who Pays? Establishing the responsible commissioner*
[2] ORDINARY RESIDENCE: Guidance on the identification of the ordinary residence of people in need of community care services, England

relevant stroke unit and are expected to follow the agreed protocol when doing so. If a patient transfer is delayed in excess of 24 hours after the agreed transfer time by a stroke unit, a HASU can:

- Keep the patient in the HASU
- Transfer the patient to the stroke unit in the same trust as the HASU
- Seek an alternative stroke unit for the patient's post hyper-acute stay.

A HASU can claim £350 per day (based on the stroke unit spell divided by the trimmed average length of stay) from the relevant PCT for patients who are not accepted by the relevant stroke unit. The PCT, in turn, can deduct this from its payment to the delaying stroke unit. This should very much be the exception and networks should monitor the situation. This rule may be modified at a later date."

From the Stroke acute commissioning and tariff guidance, available online.

Finalised details and processes to be determined at the next repatriation meeting (early 2012).

PROTOCOL FOR TRANSFER OF MIMICS WHEN DIAGNOSIS NOT STROKE

- This protocol is for FAST+ patients who are not found to suffer an acute stroke.
- Stroke mimics should be discharged home directly from ED, HASU or AMU where possible.
- Stroke mimics who cannot be discharged directly home should be repatriated within 24 hours of a non-stroke diagnosis being made to the patient's local hospital AMU or equivalent unit/ward, if clinically appropriate.
- The patient's local receiving hospital has a responsibility to accept these patients from the HASU or AMU of the HASU hospital.

Operational Policy for FAST+ patients brought to a HASU

In the Emergency Department

- Patients should be met and assessed by stroke/neurology consultant/registrar or stroke nurse.
- If the patient has a suspected/confirmed stroke, the existing pathway of assessment for thrombolysis and/or HASU admission is unchanged. All patients admitted with a stroke (suspected or confirmed) go to the HASU.
- If a stroke is excluded in the ED phase of their assessment the patient is referred by the Stroke/Neurology Registrar to the Registrar of the appropriate specialty/A&E and admitted (AMU) **within the same trust** or **discharged home** as appropriate.

On the AMU

- If the patient cannot be discharged home directly from the AMU, they should be referred to their local AMU and be repatriated within 24 hours of referral.
- The Medical Bed Manager will inform the receiving AMU bed manager of the patient upon admission to the AMU.

On the HASU

- If a stroke is excluded following further investigation and assessment on the HASU, the patient should be **transferred within 24 hours of referral acceptance and medical stability** in line with the referral processed outlined above.
- The HASU/AMU team should hand over the patient to the receiving medical team with a completed discharge summary and telephone handover.
- **If over 24 hours from referral,** follow the escalation policy as found in Appendix 1 - Escalation process for delayed transfers to SU.
- While patients should not be moved while awaiting repatriation, in cases that may compromise the HASU's ability to take stroke patients, mimics may be moved to an appropriate ward within the HASU hospital under the care of that speciality. This will help to ensure HASU bed availability at all times.
- When the receiving AMU cannot accept the patient within 24 hours, the HASU/AMU bed manager should transfer the patient to an appropriate medical ward/AMU while awaiting transfer.

Mimics: Referral process, contacts for repatriation and escalation

from a site with a HASU to South London hospital AMUs (or equivalent)

(as of 20th December)

Sector	Hospital	Referral process	Escalation after 24hrs (e.g. general managers, bed managers)
South East London	**King's College Hospital** 020 3299 9000	Neurosciences Bed Manager: bleep 746 via switchboard (0830-1530)- Mon-Fri and out of hours Site Management Team via switchboard 020 3299 9000	**Mon-Fri** Service Manager: Stroke and Rehabilitation Medicine on 020 3299 1333 **Weekend** Site Management Team via switchboard 020 3299 9000
	Lewisham Hospital 02083333000	Clinical site managers bleep 5705/7999 via switchboard to request a bed once the appropriate referral has been made and accepted by the on-call medical/surgical team (see Appendix 8)	**Mon-Fri** Sive Cavanagh #6676 or mobile via switchboard **Weekend** On call manager via switchboard
	Princess Royal University Hospital 01689 -863000	Bed site manager – Bleep 427, via switchboard on 01689-863000. To request allocation of a bed following acceptance from an appropriate on call medical/surgical team.	**Mon-Fri** Caroline Willis, General Manager For Emergency and Acute Medicine 01689-865880 / Mob: **7713396544** **Weekend** On call manager via switchboard
	Queen Elizabeth Hospital 0208-836-6000	Site Management Team, via switchboard on 0208-836-6000. To request allocation of a bed following acceptance from an appropriate on call medical/surgical team	**Mon-Fri** Paul White, General Manager for Emergency & Acute Medicine 02088365424 **Weekend** On call manager via s/board
	St Thomas' Hospital 020 7188 7188	Site Nurse Practitioner via Switchboard bleep 0162 . If necessary out of hours also contact on call medical consultant	**Mon-Fri** Liz McAndrew GM 0207188 0517 **Weekend** Site nurse practitioners bl 0162
South West London	**Croydon University Hospital** 0208 4013 000	Site Practitioner/Bed Management Team ext 3427 or bleep 145 via s/b to request allocation of bed. SP will identify a bed on MAU where possible. If bed not available discuss with consultant on call to determine appropriate bed.	**Mon-Fri** Lorraine Walton Operations Centre manager 020 8401 3427 Bleep 545 **Weekend** Manger on call via switchboard
	Kingston Hospital 020 8546 7711	Patient should be referred to the medical registrar on call (bleep 174 at Kingston) and the advanced site practitioner/bed manager on bleep 504 should also be contacted once the patient has been "accepted" by the on call medical team.	**Mon-Fri** Tracey Moore 0208 934 2622 **Weekend** On call manager via switchboard 020 85467711
	St George's Hospital 020 8672 1255	Bed Site Manager on bleep 6007 via switch board to request allocation of bed **AFTER** referral of pt to appropriate medical/surgical team	**Mon-Fri** General manager for Acute Medicine (Jane Fisher) via switchboard **Weekend** General Manager on call via switchbd
	St Helier Hospital 020 8296 2000	Medical registrar on bleep 400 via switchboard 020 8296 2000 to refer the patient and clinical site manager (24/7) on bleep 443 (8am to 8pm) or bleep 446 (8pm to 8am) via switchboard or on 020 8296 2886 (voicemail only service to leave a message) to facilitate timely repatriation	**Mon-Fri** General Manager Lesley Nolan 07795540597. **Weekend** On call manager via switchboard

PROTOCOL FOR VASCULAR SURGERY

- Carotid endarterectomies should take place as soon as possible (no more than two weeks wait). There should be local arrangements to decide where patients have this procedure, including transfer arrangements. These will be determined as per the London Cardiovascular Project: South East London services will be centralised at St Thomas' Hospital; South West London services will be centralised at St George's Hospital.
- If patients are identified in out-patient TIA clinics with symptomatic high grade stenosis, there should be a local arrangement in place to admit them to a stroke ward for consideration of urgent vascular surgery.
- High grade carotids should be discussed with the on-call stroke physicians at the HASU to arrange admission if required.

PROTOCOL FOR 24/7 NEURORADIOLOGY ACCESS

Local arrangements should be in place, but networked solutions should be considered where neuroradiology resources are limited.

APPENDIX 1 – ESCALATION PROCESS FOR DELAYED STROKE TRANSFERS FROM HASU TO SU

Stroke Unit	**24hrs** **e.g. General manager / Bed managers**	**48hrs** **e.g. General manager, Div. Dir. Ops**	**72hrs** **e.g. COO**	**>72hrs** **e.g. CEO**
St Georges Mon-Fri	Natasha Dillon (Matron) / Tara May Tyrer (Stroke coordinator) 0208 672 1255 X4783/4785 or bleep 7933	Katie Cusick (GM) / Gayathri Sivaplan (AGM) 0208 672 1255 X4483 07825116016	Chloe Cox (DDO), ? (COO) Via switchboard 0208 672 1255	(COO), Miles Scott (CEO) Via switchboard 0208 672 1255
St Georges Weekend	Nurse in charge – Brodie Stroke Ward 0208 672 1255 X4783	Site Manager 0208 672 1255 Bleep 6007	GM on call Via switchboard 0208 672 1255	Director on-call Via GM oncall Via switchboard 0208 672 1255
Kingston Mon-Fri	Advanced Site Practitioner 0208 546 7711 Bleep 504	Tracey Moore Divisional manager Via switchboard 020 85467711	Sarah Tedford COO Via switchboard 020 85467711	Sarah Tedford COO Via switchboard 020 85467711
Kingston Weekend	Advanced Site Practitioner 0208 546 7711 Bleep 504	Tracey Moore Divisional manager Via switchboard 020 85467711	Sarah Tedford COO Via switchboard 020 85467711	Sarah Tedford COO Via switchboard 020 85467711
Croydon UH Mon-Fri	Ajay Boodhoo Nurse Stroke Practitioner 0208-4013000 bleep 252	Heather Hadizad General Manager Emergency Care 0208401 3000 ext 3593, bleep 364 from June 30th 2012 will be KatharineBrothwood	Mark Kemp ADO Emergency Care 0208401 3000 ext 3151 from 30th June 2012 will be Elaine Clancy ADO	Richard Parker - Director of Ops Via switchboard 020 8401 3000
Croydon UH Weekend	Site Practitioner on call bleep via switchboard 020 8401 3000	On call manager Contact via switchboard 020 8401 3000	On call director Contact via switchboard 020 84013000	On call director Via switchboard 020 8401 3000

St Helier Mon-Fri	Stroke Nurse Consultant -Wendy Brooks 0208296 2000 Bleep 917 OOH On call medical SpR 020 8296 2000	Charlotte O'Brien, St Helier site GM vIa switchboard 020 8296 2000	Deborah Frodsham. DDO, Emergency care via switchboard 020 8296 2000	Karen Breen COO via switchboard 020 8296 2000
St Helier Weekend	OOH On call medical SpR 020 8296 2000 Bleep 400 Bed Manager 020 8296 2000, Bleep 576 (OOH bleep 443)	On-call General Manager Via Switchboard 020 8296 2000	On-call Director Via Switchboard 020 8296 2000	On-call Director Via Switchboard 020 8296 2000
GSTT Mon-Fri	Gill Cluckie, Clinical Lead and Andy Willis Via switchboard 020 7188 7188 Site Nurse Practitioner Via switchboard 020 7188 7188 / bleep 0162	Gill Cluckie, Clinical Lead and Karen Heng Via switchboard 020 7188 7188 Site Nurse Practitioner Via switchboard 020 7188 7188 / bleep 0162	Gill Cluckie, Clinical Lead and Neil Macdonald Via switchboard 020 7188 7188 Site Nurse Practitioner Via switchboard 020 7188 7188 / bleep 0162	Director of clinical services, Jon Findlay 020 7188 7073
GSTT Weekend	Site Nurse Practitioner via Switchboard and HASU consultant via switchboard 020 7188 7188 / bleep 0162	Site Nurse Practitioner via Switchboard and HASU consultant via switchboard 020 7188 7188 / bleep 0162	Site Nurse Practitioner via Switchboard and HASU consultant via switchboard 020 7188 7188 / bleep 0162	On-call Director via switchboard 020 7188 7188
PRUH Mon-Fri	Caroline Willis, 01689 865880 07713396544	Caroline Willis, 01689 865880 07713396544	Director of Operations 020 8836 5928	Jenny Hall Deputy Chief Operating Officer 020 8302 2678 ext. 2875
PRUH Weekend	Manager On Call via Switchboard 01689 863000	Manager On Call via Switchboard 01689 863000	Director On call via Switchboard 01689 863000	Director On call via Switchboard 01689 863000

KCH Mon-Fri	Consultant Nurse Maria Fitzpatrick 02032994084 or 07528977464 and HASU consultant via switchboard 020 3299 9000 Site Management Team via switchboard 020 3299 9000, bleep 333 There is an oncall manager available through switchboard OOH.	Maurizio Privitelli, Service Manager 02032991333 and HASU consultant via switchboard 020 3299 9000 Site Management Team via switchboard 020 3299 9000, bleep 333. There is an oncall manager available through switchboard OOH.	Harriet Livesey, Divisional Manager 02032992670 and HASU consultant via switchboard 020 3299 9000 Site Management Team via switchboard 020 3299 9000, bleep 333 There is an oncall manager available through switchboard OOH.	Chief Operating Office Roland Sinker or CEO Tim Smart 020 3299 3270 / 2124 and and HASU consultant via switchboard 020 3299 9000 Site Management Team via switchboard 020 3299 9000, bleep 333 There is an oncall manager available through switchboard OOH.
KCH Weekend	Site Management Team via switchboard 020 3299 9000, bleep 333and HASU consultant via switchboard. 020 3299 9000	Site Management Team via switchboard 020 3299 9000, bleep 333and HASU consultant via switchboard. 020 3299 9000 On call manager available through switchboard OOH.	Site Management Team via switchboard 020 3299 9000, bleep 333and HASU consultant via switchboard. 020 3299 9000 On call manager available through switchboard OOH.	Site Management Team via switchboard 020 3299 9000, bleep 333and HASU consultant via switchboard. 020 3299 9000 On call manager available through switchboard OOH.
Lewisham Mon-Fri	Bed Manager 020 8333 3000 Bleep 5705	Sive Cavanagh 020 8333 3000 Extension 6676 Or mobile via switchboard	Katy Wells 07768398937	Claire Champion, Director of Ops Via switchboard 020 8333 3000
Lewisham Weekend	Bed Manager Bleep 5705 via switchboard 020 8333 3000	Bed Manager Bleep 5705 via switchboard 020 8333 3000	On call Operational Manager via switchboard 020 8333 3000	On call Executive via switchboard 020 8333 3000
QEH Mon – Fri	Jemma Wells 020 8836 4334	Paul White 020 8836 5424	Director of Operations 020 8836 5928	Jenny Hall Deputy Chief Operating Officer 020 8302 2678 ext. 2875

QEH Weekend	Manager On Call via Switchboard 020 8836 6000	Manager On Call via Switchboard 020 8836 6000	Director On call via Switchboard 020 8836 6000	Director On call via Switchboard 020 8836 6000

APPENDIX 2 – LAS EMERGENCY DEPARTMENT TO HASU TRANSFER POLICY

This protocol is to be used when a stroke patient presents (either as a self presenter or by LAS) at an Emergency Department of a Trust that does not have a Hyper Acute Stroke Unit (HASU) and/or an acute Stroke Unit (SU).

If a patient presents at an Emergency Department of a multi sited Trust with a HASU the Trust should have an internal mechanism for ensuring that the patient is admitted to the Trusts HASU. That internal mechanism may involve LAS as stated below.

Actions to be taken if stroke patients present at a hospital without a HASU and/or stroke unit

There are a number of scenarios under which patients with a possible stroke may present at an Emergency Department of a Trust without a HASU and/or SU. This guidance will provide an overview of the most commonly encountered scenarios and the steps to be taken to support timely and safe transfer.

Patients presenting at ED (self-presenter or patients brought in by ambulance:

1. **Within the thrombolysis window (currently 4 ½ hours)** - Patients presenting at an ED within the thrombolysis window (within 4 ½ hours of onset of stroke), should be transferred to a HASU using LAS as a critical transfer.

2. **Within 24 hours of onset of symptoms but outside 4 ½ hour thrombolysis window** - Patients should be transferred to a HASU by LAS within 2 hours. These transfers will be arranged through the Urgent Operations Centre as per the flowchart.

3. **More than 24 hours after onset of symptoms** - Following a clinician-to-clinician discussion between the medical lead at the referring trust and the lead stroke physician at a HASU, consideration should be given by the assessing clinician to transferring the patient to a HASU. In the rare circumstances that this is not considered by the assessing clinician to be appropriate the patient must be transferred to (own or nearest) stroke unit. If the assessing clinician determines the patient should go to a HASU, the HASU clinician will not refuse the patient. In the event that the HASU clinician refuses to accept the patient, the assessing clinician will escalate this to the manager on-call for the HASU host trust.

As this transfer is unlikely to be time critical, the referring hospital's Patient Transport Service (PTS) should be used for the transfer. If advice about the transfer is required the hospital should contact the Clinical Support Unit at LAS (The hospital should be aware that any LAS PTS service for which the hospital does not hold a LAS contract is chargeable).

To facilitate timely transfer, a full patient history should be taken and if immediate medical management of the patient is required, the patient must be stabilised prior to transfer. Patients will receive full investigation and acute management upon transfer to a HASU. Further examination and investigation at the hospital, which may include CT scan, should be performed only where clinically indicated. This will be dictated by clinical judgment and should not delay the transfer of the patient.

Transfers relating to paragraph 1 above should be arranged as per the flow chart below (red box). LAS Emergency Operations Centre (EOC) will coordinate conveyance to the most appropriate HASU based on real time review of capacity and demand. Capacity issues at the receiving trust will not affect patient transfer. The receiving trust is responsible for actively managing capacity to accommodate new transfers. Transfers relating to paragraph 2 above should be arranged per the flow chart below (yellow box). The Emergency Department clinician will contact the local HASU (normally the HASU local for the patient) to refer the patient and the ED staff will contact LAS to arrange the transfer.

NOTE: All transfers of patients from HASUs to SUs or to other Emergency Departments are not covered by this protocol. They are separately covered by the HASU to SU protocol and are the responsibility of the HASU hospitals' PTS except for critical transfers which will continue to be managed by the LAS. This includes patients brought to the ED of a HASU and subsequently found to not be suitable for a HASU bed.

APPENDIX 3 – SOUTH LONDON STROKE PATIENT NOTIFICATION SHEET

STROKE PATIENT NOTIFICATION RECORD

	Date of Birth	Post code	Referral Date	Predicted Date Fit For Transfer	Hospital	Date Bed Offered	Infection Status	Side Room Required	Date fit for transfer	Date Of Transfer	Time Of Transfer	Record of contact with HASU/SU
			HASU – complete with date referral sent to SU SU – complete with date referral received	HASU determine this	HASU- complete with hospital referring patient to. SU - complete with hospital receiving patient from	HASU& SU – date SU confirm they will be able to receive the patient	show as Pos or Neg	Y or N	Agreed by both HASU and SU	HASU complete with date patient left HASU SU complete with date patient arrived on SU	HASU complete with time patient left HASU SU complete with time patient arrived on SU Record using 24 hour clock	Show Date and outcome Outcome:
A N Other	01/01/1931	CR4 2BZ	26/03/2011	27/03/2011	SGH	28/03/2011	pos	n	27/03/2011	28/03/2011	13.55	27/3 spoke with nurse in charge single room bed for MRSI positive pt not available until noon tomorrow

APPENDIX 4 – KCH ACUTE STROKE UNIT PATIENT TRANSFER DOCUMENT

Checklist to accompany transfers

Is the patient a _____ resident?		Y/N
Does s/he have a diagnosis of stroke?		***Y/N***
Discharge summary		Y/N
Drugs on transfer		Y/N
Nursing transfer letter	***Y/N***	
Therapy transfer letter	Y/N	
Copies of inpatient notes		Y/N

Copies of relevant investigations attached

_____

_____

_____

_____

CT/MRI images provided:	(✓)
Image linked	☐
CD with patient	☐

List of outstanding investigations

_____

_____

_____

_____

Has the patient been entered into a research trial Y/N

If so, details

_____

_____

Name of HASU consultant

_____

APPENDIX 5 – SGH ACUTE STROKE UNIT PATIENT TRANSFER DOCUMENT

(Please keep a photocopy of this form on the ASU)

Except in exceptional circumstances patients should not arrive at the receiving ward after 9pm. If transport has not arrived by 8pm please discuss with bed managers and cancel transport and rearrange for transfer the following morning.

Name of Physician confirming medically stable to transfer:

Patients Name: Hospital No: Date of Birth: Property with patient: Y / N	NOK Address/Relationship: Informed of Transfer: Y / N
Date & Time transport booked by staff	**Date and Time of agreed & booked transfer of patient.**
Date & name of person accepting transfer	Notes with patient : Y / N Imaging details with patient : Y / N Medication with patient: Y / N
Main Diagnosis **Relevant Past Medical History**	
Care Assessments	
Neurological:	
Respiratory :	
Cardiovascular:	
Other :	
Infection Control	
MRSA Status: Y / N. If Yes state treatment plan	
Clostridium Difficile : Y / N	
Diarrhoea :Y / N in last 24 hours Norovirus risk: Y / N	

Risk assessments
MUST nutritional screening tool score :
Moving & Handling score :
Waterlow score : Is air mattress required? Y / N
Weight is above 120KG Y / N If Yes What special equipment is needed?
Is the patient aphasic? Y / N
Wounds
Pressure sores Y / N If Yes when did they occur & what treatment has been started
Elimination
Urinary Catheter in situ Y / N If Yes state when inserted and Why?
Bowels last opened
Nutrition
Naso- gastric tube inserted Y / N state when inserted and reason for insertion Feeding regime attached Y / N Circle Oral intake : Puree Easichew Soft Normal Circle fluid consistency : Syrup thickened Thin
Intravenous cannulae Y / N If Yes date inserted
Mobility
Circle walking ability: Independent 1 nurse 2 nurses Walking Aid Method of transfer: Independent 1 nurse 2 nurse Standing Hoist Hoist Circle wheelchair type: Standard Tilt in space
Other relevant Information
Name and grade of ASU unit nurse giving handover about patient:
Name and grade of nurse receiving Telephone handover before leaving the stroke unit :

APPENDIX 6 – PRU ACUTE STROKE UNIT PATIENT TRANSFER DOCUMENT

HYPER ACUTE STROKE UNIT
PRINCESS ROYAL UNIVERSITY HOSPITAL
FARNBOROUGH COMMON
ORPINGTON KENT BR6 8ND
Tel: 01689 863357
Fax: 01689 863353

PRUH transfer sheet – Page 1

NAME ……

DOB ……

ADDRESS ……

……

……

……

NOK / NO ……

……

GP ……

……

……

……

REPAT HOSPITAL AND WARD:

……

CHECKLIST:

COPY OF MEDICAL NOTES ☐

COPY OF NURSING NOTES ☐

COPY OF DRUG CHART ☐

TTO / MEDICATIONS ☐

SCAN CD INCLUDED ☐

FAMILY INFORMED ☐

TRANSPORT BOOKED AND TIME……☐

DISCHARGING NURSE……

SIGNATURE……

DATE……

ADMISSION REASON

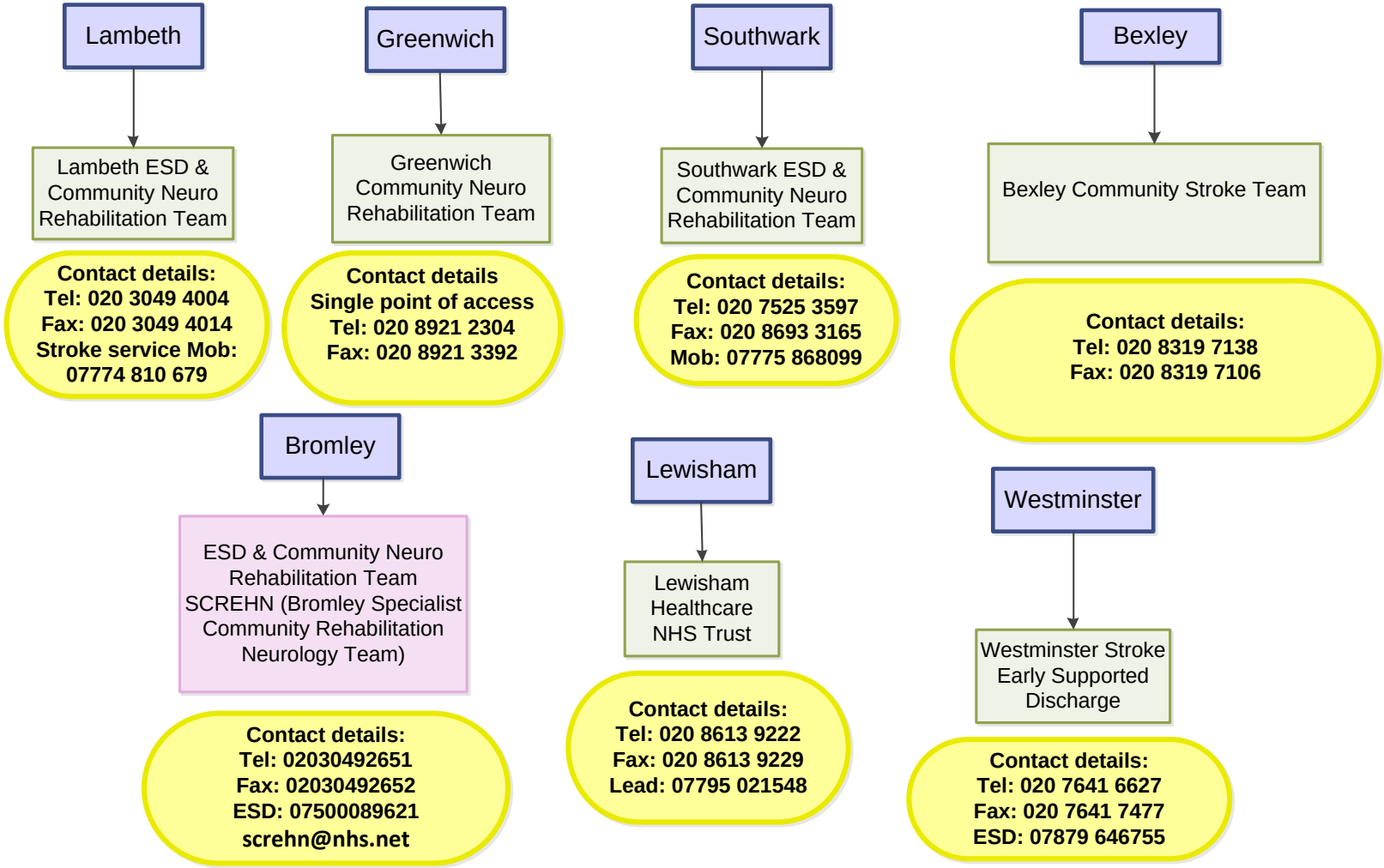
PAST MEDICAL HISTORY

I have enclosed a photocopy of their nursing and doctor's notes for this admission with us here at the PRUH. Here is a brief outline of their capabilities:

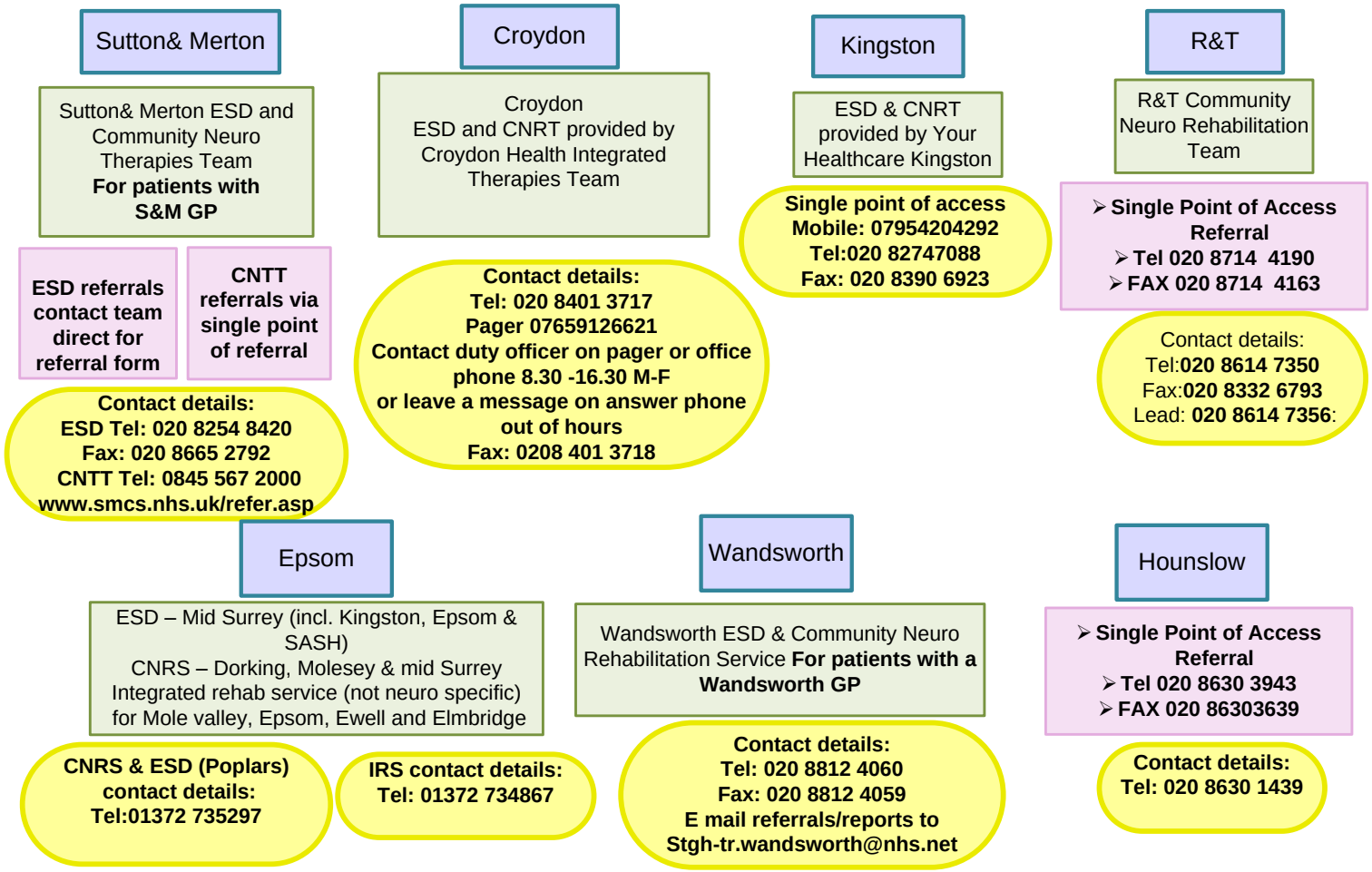
NURSING NEEDS/ NEURO ASSESSMENT	**CONTINENCE**
COGNITION / ORIENTATION	**BREATHING AND CIRCULATION**
WASHING AND DRESSING	**COMMUNICATION**
SWALLOW AND NUTRITION	**SKIN**
TRANSFERS AND MOBILITY	**PAIN**
SAFETY	**CURRENT MEDICATIONS**

Any issues do not hesitate to ring us here on the ward. Many thanks.

APPENDIX 7 - SE LONDON REFERRALS TO COMMUNITY AS AT APRIL 2013



APPENDIX 8 - SW LONDON REFERRALS TO COMMUNITY AS AT APRIL 2013



APPENDIX 9 – LEWISHAM TRANSFER OF MIMICS FROM HASU TO LEWISHAM HOSPITAL

Stroke mimic on HASU site

↓

Patient medically stable?

i.e. Not requiring ITU/NIV

↓

Bleep 1000 (Medical Registrar on call at LHT)

↓

Medical registrar accepts patient under

Physician on call & informs LHT Clinical Site Manager (bed manager)

↓

Clinical Site Manager at LHT identifies bed

on MAU & informs HASU

↓

Patient transferred to LHT MAU with:

-discharge letter & drugs on transfer

-copies of inpatient notes

-copies of relevant investigations

-image links of all relevant CT/MRI

-list of outstanding investigations