Stroke Patient Handoff Tool

Transfer Handoff Report
Clinical Summary to include:
• Stroke Diagnosis • PMH such as Atrial fibrillation, HTN, Diabetes etc., • Allergies
• **Clinical Status:** Including: ○ Recent VS (including BP and any treatment of BP) ○ NIH score with description of current deficits ○ Time LKW or witnessed time of symptom onset ○ Treatment received (i.e. Thrombolytic and dose or reason not given) ○ Post-Thrombolytic 24 VS/Neuro Check Next Assessment Due (if possible assessment copy) ○ ICH Score when appropriate and available ○ Dysphagia Status (screening completed and if passed/failed, NPO) ○ Lab results ○ Image results ○ Family Contact phone number
** **Core Measure Status when applicable**: Including: ○ Antiplatelet initiated and last dose ○ VTE Prophylaxis initiated (SCDS or pharmacological) and last dose if pharmacological
Status of Stroke/TIA Admission Order Sets: Order Set initiated and if not initiated rationale for not initiating

Shift to Shift Bedside Report
• Clinical summary • Plan of care/treatment • Pending orders/tests • New or changed medications • Stroke/TIA diagnosis confirmed (Yes/No): Imaging pending? • New Medications or medication revision (For AIS, is patient on antiplatelet, statin if LDL >70, Anticoagulation if positive for Afib/Aflutter)

- Stroke/TIA Patient/Caregiver Education (such as personal risk factor and education that has been completed and what needs reinforced)
- Discharge Plan/Transitions Plan Status

- Complete NIHSS together at shift change
- With any change in Neuro deficits of NIHSS greater than or equal to 2, report this change

- Dysphagia screening status (Pass/Fail)
- Nutrition/Hydration Plan
- If NPO (include Speech Therapy and Dietician on case if failed dysphagia screening)

Core Measure Status and Consults needed:

On Admission:

- Dysphagia evaluation prior to any oral intake
- Lipid Profile and Hemoglobin A1C
- Social Service
- Stroke Education Initiated
- Rehab Consult initiated

On or Before Day 2:

- Antiplatelet therapy
- VTE prophylaxis
- Rehab consult completed

Prior to Discharge:

- Stroke Education completed
- Antiplatelet therapy
- Intensive Statin or Contraindication Documentation
- Anticoagulation plan for Atrial Fibrillation diagnosis

Nursing Care Plan:

- Diagnoses Based on Patient's Assessed Needs and Patient's Goals for today
- Display mutually agreed upon goals in patient room. Include in report if patient's goals have been met on previous shift and any needed education for patient to complete goals
- Multidisciplinary Rounding Documentation in Chart when applicable

Stroke Education: Include Personalized Risk Factors discussed and document in EMR

Discharge Plan:

- Status of discharge plan (including if home or rehab recommendations) and if social services consulted
- Also include referrals completed and arrangements for post discharge care