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Welcome to the Autumn 2018 edition of the Scottish Stroke Nurse Forum Newsletter

A word from our Chair

In 2001 the SSNF was founded by a small group of nurses with an interest in stroke. Since then we have gone from strength to strength. This year will be our 15th annual conference and the committee, especially Craig Forman has worked hard to pull this day on Senses and Stroke together and we hope that you will enjoy the varied programme on offer.

2017/2018 has been another challenging year with increasing pressures on our workloads but despite this the Scottish Stroke Care Audit shows a continuing improvement in stroke care across Scotland and if we look back at when the SSNF first started the changes have been immense. We still have many standards to meet within the Stroke Improvement Plan and the SSNF intends to work in partnership with others to rise to this challenge.

The comings and goings of the SSNF committee have been many in 2017/2018. We saw the first health care assistant Norma Moir from NHS Fife sit on the SSNF Committee and she will represent the thoughts, opinions and issues that affect HCA working in stroke. Norma is a wee bit lonely just now and she could do with some company and we would welcome more representation from HCA if you are interested let us know. Hazel Fraser, Jo Booth and Peter Kerr have all left the committee and after this conference we will also lose Mhairi Chrystal and Hannah Evans and I would like to thank them all for their input and dedication to the SSNF. If you can spare a few hours why not think about joining the committee.

We have had a revamp on our website www.snnf.scot/ thanks to Jason MacMillan and the team at CHSS. We have added our tweets to the site and even if you are not on Twitter you can see what is trending. The membership form, meet the committee and general information have all been updated. We plan to post links to new articles, guidelines, stroke improvement days and examples for revalidation on shortly as well as the updated SSNF Work-plan (2017-2022) and notes of the quarterly Committee Meetings.

The SSNF now has representation on the National Advisory Committee, The Cross Party Working Group for CHD and Stroke, SSCA, Vision and Hearing Network, The UK Stroke Forum and The National Stroke Nursing Forum. We also nominate our members to participate in the development of new policies, guidelines and research projects. The SSNF will continue to make sure that the voice of our members are heard and that our opinions and values are upheld and listened to.

Our members have a number of articles published in Journals in the last year and have even participated in a Podcast, a whole new experience, see more about this in the newsletter. We have also participated and contributed to a number of research projects and questionnaires including on mindfulness, hypertension and AF.

On Oct 3rd 2018 many of our members will be involved in looking at the role of the stroke liaison nurse / specialist nurses in meeting standards 7 and 8 of the Stroke Improvement Plan through a Stroke Improvement Workshop. If you get the chance to attend these Improvement Days please go they are invaluable for sharing of good practice and you will come away enthused and full of ideas on improving care in your area.

Finally, let's carry on the good work. It is 70 years since the NHS was founded to give free care for all, what a difference that has made. It is 17 years since the SSNF was founded and we have made a difference. Let's continue our fight as nurses to improve stroke care, improve outcomes and to work with our colleagues, patients and their families to make this happen and in the words of Chest Heart and Stroke Scotland have NO LIFE HALF LIVED.

Linda Campbell, SSNF Chairperson

CHSS launches new strategy to fight for No Life Half Lived in Scotland

In May, Chest Heart & Stroke Scotland (CHSS) launched its new vision and strategy; No Life Half Lived. There are over one million people in Scotland living with the effects of serious chest and heart conditions and stroke. The ambitious new strategy aims to address the unmet needs of people who are living with these conditions – social, emotional and physical – across Scotland.

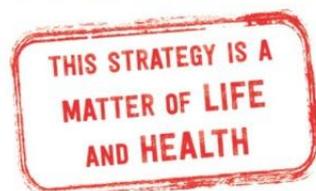
To do this, by 2021 CHSS will double the number of people they reach by launching the No Life Half Lived Support Service, and increase the support available to people and their families through their specialist nurses, community groups, advice and information.

Commenting on their new vision, Jane-Claire said, "Every single day in Scotland there are people and families whose worlds are being turned upside down after a diagnosis of chest or heart condition or a stroke. Many people can experience fear and isolation and are struggling from the impact on their lives. Not everyone is getting the care and support they need. We won't stand for that. We want to make sure life with chest, heart or stroke conditions is a life lived to the full!"

"In order to meet this need and ensure no life half lived in Scotland we need to double our income, double the number of our volunteers and double the amount of people through our services. We will achieve this by being led by people with chest, heart and stroke conditions and informed by their families and carers, friends, colleagues and healthcare professionals."



NO LIFE HALF LIVED



Spasticity Study Day

NHS Fife in partnership with Chest Heart & Stroke Scotland were delighted to host a study day focusing on the management of spasticity which was supported by Allergan. The purpose of this day was to improve knowledge and skills around spasticity and in particular, try to engage colleagues in the service development which is progressing within this field in Fife and further develop our spasticity network. We initially advertised this day within NHS Fife and then proceeded to advertise it within the Scottish Stroke Nurse Forum and the Scottish Stroke AHP Forum to ensure that some places could be taken up by staff out with Fife. We received a huge amount of interest from across the country and the day was fully booked up as well as having an extensive reserve list. The event proved to be a great success with a range of speakers from across the country sharing their expertise in this topic. Due to sponsorship from Allergan we were lucky enough to secure Professor Anthony Ward as our key note speaker who remained with us throughout the day to discuss this topic with all who attended, as well as run a small workshop aimed at key personnel within Fife which focused on more complex patient assessment and injection techniques using Botulinum toxin type A. Both patients who took part in this workshop are now progressing with their treatment following on from the assessment and treatment that they received from Professor Ward.

Other presenters who very kindly agreed to join us was, Mark Smith, Consultant AHP/Physiotherapist, NHS Lothian who gave an overview of the national picture on spasticity. Irene Nicol, Specialist Nurse, Spasticity Management Service, NHS Lothian whom discussed the role of nurses in spasticity management. Susie Hughes, Advanced Specialist Orthotist, NHS Greater Glasgow & Clyde, who informed everyone on the use of orthoses in spasticity management and Dr Niall Hughes, Stroke Consultant, NHS Greater Glasgow & Clyde who gave a very interesting perspective on how a real life spasticity service / clinic can be developed and managed. Each presenter managed to bring their own unique perspective to the day and discussed many thought provoking elements. This has only added to the motivation that currently exists in health professionals to improve on how they manage spasticity as well as create new services within NHS boards or continue to improve on those that already exist. A workshop which was held in the afternoon asked attendees to look at differing elements of how spasticity is managed within their own areas and this has been very useful to the NHS Fife spasticity network in allowing us to focus on what already exist and what can be built upon in the future. Many attendees commented in the evaluations how useful it was to have speakers from across the country come to Fife to share their expertise but most commonly mentioned was how useful it was to learn from each other and network with staff from as far up as the Highlands and Western Isles down to NHS Borders.

As a result of this event, work is progressing in Fife on a Fife wide spasticity service and has only increased the enthusiasm that exists across the board on how this service can be developed further. Joanne and Charlie would like to thank all of the presenters for travelling across the country to present at this event and share their knowledge and skills with the audience, however we would also like to thank all who attended and shared their own experiences of spasticity management on the day as this will now help us to develop our Fife Wide spasticity service further.

For further information about this event or any education and training enquiries related to NHS Fife please contact: Joanne Graham, Stroke Education Facilitator, Chest Heart & Stroke Scotland in partnership with NHS Fife at joanne.graham@nhs.net Or for more information about the Fife Wide spasticity network please contact Dr Charlie Chung, Rehabilitation Manager and Stroke Specialist Occupational Therapist, NHS Fife at Charliechung@nhs.net



Scottish Stroke Nurse Forum Newsletter

ESOC - Gothenburg 2018

ESOC – Gothenburg

I was very fortunate to have a poster presentation accepted and was able to travel to the European Stroke Conference (ESOC) in Gothenburg in May this year. Gothenburg is a beautiful city and the weather was excellent with bright blue skies and locals telling us this was a little unusual for the time of year.



Poster presentation ready with Dr Richard O'Brien



Some of Edinburgh Contingent at ESOC 2018

Conference is always a chance to catch up with old friends / colleagues and lots networking, this conference was no different. It's reassuring that many of the issues we have are common wherever you are. Problem solving and sharing good practise from poster presentations is a way to showcase this. The poster that I presented with my colleague Dr Richard O'Brien was a focus on intermittent pneumatic compression compliance using quality improvement methodology and demonstrated the challenges of getting research evidence into practise.



How do outcomes differ between patients with mild stroke, more severe stroke and a final non-stroke diagnosis who are thrombolysed? A retrospective data analysis.

M Turner¹, P Langhorne², M-J Macleod³

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INTRODUCTION

Thrombolysis is a time sensitive therapy and a combination of the best time to give it is not clear. For new users of this therapy, it is important to know what the outcomes are for different groups of patients.

AIMS

To compare the effect of stroke severity and a final non-stroke diagnosis on outcomes in patients who have been thrombolysed.

METHODS

Retrospective data analysis of patients who have been thrombolysed in the UK between 2010 and 2017.

RESULTS

Stroke Severity	Median LOS (days)	Median LOS (days)	Median LOS (days)
Mild	11.0	11.0	11.0
Severe	11.0	11.0	11.0
Final non-stroke diagnosis	11.0	11.0	11.0

CONCLUSIONS

There were no significant differences in outcomes between patients with mild stroke, more severe stroke and a final non-stroke diagnosis who were thrombolysed.

IS POST-ACUTE, COMMUNITY BASED REHABILITATION IN SCOTLAND EVIDENCE BASED?

Richard D'Amico¹, Sara Bayliss², Neil Blair³, Nadine Brennan⁴, Terence Quinn⁵, Lynn Reid⁶, Martin Walker⁷, Peter Langhorne⁸

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INTRODUCTION

Stroke is a global health problem and a leading cause of disability. Rehabilitation is a key component of stroke care and is essential for improving outcomes. However, there is a lack of evidence on the effectiveness of community based rehabilitation (CBR) in Scotland.

AIMS

To determine the level of community based rehabilitation services in Scotland and to identify the evidence base for CBR in Scotland.

METHODS

A literature search was conducted to identify the evidence base for CBR in Scotland. The search was limited to English language articles published between 2000 and 2017.

RESULTS

There were 10 articles identified in the search. The majority of these articles were focused on the effectiveness of CBR in improving outcomes in stroke survivors.

CONCLUSIONS

There is a need for more research on the effectiveness of CBR in Scotland. The current evidence base is limited and more research is needed to determine the level of CBR services in Scotland.

Mobile Stroke Unit Treatment of Suspected Stroke in Rural Alberta

A. Shauk¹, S. Arora², M. Kaur³, S. Dhillon⁴, K. Singh⁵, S. Bhat⁶, K. Bhat⁷, M. Sood⁸, T. Jassal⁹

¹University of Alberta, ²University of Alberta, ³University of Alberta, ⁴University of Alberta, ⁵University of Alberta, ⁶University of Alberta, ⁷University of Alberta, ⁸University of Alberta, ⁹University of Alberta

INTRODUCTION

Rural ischemic stroke patients may potentially benefit more from Mobile Stroke Units (MSUs) than urban patients treated in a general structure in stroke centers to improve time to treatment. However, rural MSUs are costly to implement. The Alberta Health Services (AHS) is currently evaluating the feasibility, safety, clinical and cost benefits of early MSU treatment in rural Alberta.

AIMS

To determine the feasibility, safety, clinical and cost benefits of early MSU treatment in rural Alberta.

METHODS

The report describes the patient, clinical and demographic variables and 90% delivery in the first 60 days.

RESULTS (CONC)

- The median 3 month mRSBS dropped significantly to 3 (Interquartile range 0 to 5) (P < 0.001).
- Of these 3 patients, one patient died, four have a score of 5, and seven are still 5, all of whom require returning home. There were no complications.

CONCLUSION

The MSU offers a novel approach to performing timely and effective treatment of suspected stroke patients in rural settings and may help reduce disability and improve the outcomes of rural stroke patients.

There were so many other posters and e-poster presentations on such a wide range of topics to many to mention. It was good to see pre and post hospital care too and lots of collaborative working

The poster area was busy and a lot of time was given to view these every day.

Trial reports

A number of new research findings were presented at the conference. Some of the readers will be aware of these studies and may well have assisted in the enrolment of patients. I have highlighted 3 that I found really interesting.

TICH – 2

Nikola Sprigg from Nottingham presented the TICH- 2 results. Currently there is little we can do for haemorrhagic stroke patients other than wait.

Tranexamic acid treatment reduced the number of deaths, bleeding in the brain and serious complications in the early days following intracerebral haemorrhage, but there was no difference in the number of people who were left disabled or had died at three months after their stroke.

WAKE-UP

Intravenous Thrombolysis in Stroke Patients with Unknown Time of Onset – Results of the Multicentre, Randomized, Double-blind, Placebo Controlled WAKE-UP Trial.

In patients with stroke of unknown symptom onset and an MRI scan suggesting limited established damage, clot-busting intravenous thrombolysis resulted in a better functional outcome than placebo and similar to patients treated within the current 4.5-hour treatment window.

This is the first positive trial of intravenous thrombolysis relying on patients selection by advanced brain imaging without information on time of symptom onset.

This means guided intravenous thrombolysis represents an effective treatment option for stroke patients with unknown symptom onset, especially for those with minor or moderate stroke who are not eligible for mechanical thrombectomy.

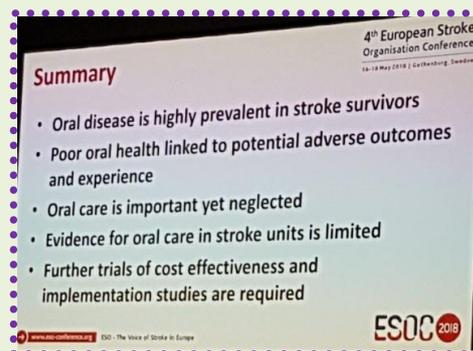
EXTRAS

A trial to Evaluate an extended Rehabilitation service for stroke patients.

Stroke Units and Early Supported Discharge (ESD) Services are the cornerstones of evidence based stroke care EXTRAS evaluated the clinical and cost-effectiveness of an Extended Stroke Rehabilitation Service provided for 18 months (n=285 patients, n=103 carers) compared with a control group (288 patients and 91 carers). Extended Stroke Rehabilitation Service did not improve stroke survivors' participation in extended activities of daily living, nor did it lead to improved patient mood. However, differences were seen in favour of the intervention in terms of satisfaction with services

What did I learn at the conference?

It is not only always about the big headline things in stroke that matters, Craig Smith from Manchester gave an excellent presentation on oral care of our stroke patients. Often the little things can make the biggest impact on patient comfort and mood.



You can get more information of the conference by following this link:

<https://eso-conference.org/2018#.W35zmfZFymR>

Journal Club

For this edition Journal Club we decided to look at the benefits of 'Pet Therapy' in Healthcare Settings. We know that people can have a very special bond with their animals. So for those patients who are separated from their pets because they are in hospital or care settings it must be very difficult. The Pet Therapy articles referred to in this Journal Club refer to dogs as therapy (sorry cat lovers). There are also links provided to information and guidance on Pet Therapy in healthcare settings. It is a very interesting topic and I am sure will resonate with many of us. And the Benefits of Pet Therapy 'Therapets' will be presented at the SSNF conference 2018. So Dogs will be present on the day.

Animals as a tool for reducing stress and managing pain has been studied since the 1980's and covers a wide range of clinical situations. Three articles have been chosen as a cross-section of what has been studied in healthcare settings and are discussed here. The three articles were Adult, non oncology and non palliative care settings. Coakley & Mahoney (2009) and Banks & Banks (2002) undertook research projects looking at the benefits of pet therapy, specifically dogs, in the clinical setting. Using peer reviewed clinical tools patient's mood, psychological and physiological states were measured and concluded. Both studies used limited numbers and the research by Banks & Banks (2002) was only carried out on patients who were known to be animal owners, which could impact on generalisability. There was also no use of a control group in either of these studies. Neither study did anything advancing of previous research undertaken to add new conclusions but they are useful in raising awareness of this treatment option and as a framework for further study. McCulloch et al (2016) takes a wider view, looking at how animals are utilised and highlighting differences in how therapy is applied in a variety of clinical settings. It also asks the question of a potential risk to those animals being used as 'Pet Therapy' as well as the lack of standardisation of therapy provision in many of the research articles it cites. Bank's & Banks (2002) describe how they try to minimise risk, by looking at allergy, previous pet interaction and states the dog used as therapy was examined by a vet before the study started. McCullough et al (2016) highlight the lack of research into the impact these interactions have on the animal involved. Both the Coakley & Mahoney (2009) and Banks & Banks (2002) studies demonstrated an improvement in mood as well as a reduction in the perception of loneliness. With the Coakley & Mahoney (2009) study showing increased energy levels in patients associated with a reduction in respiratory rate and perceived pain. Both these articles conclude that 'Pet Therapy' was effective in reducing stress caused by hospitalisation or long term care as well as being meaningful to the participants and an inexpensive treatment option. Interestingly only earlier this year (14th May 2018) the Royal College of Nursing (RCN) published a protocol to support organisations considering working with dogs in health care settings and allied environments.

References:

- Banks M.R. & Banks, W.A. (2002). The Effects of Animal-Assisted Therapy on Loneliness in an Elderly Population in Long-term Care Facilities. *Journal of Gerontology*. [online] 57a(7). pp.427--432. Available at: <http://academic.oup.com/biomedgerontology/article-abstract/57/7/m428/553460> [Accessed 1st August 2018].
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- McCullough, A. Ruehrdanz, A. Jenkins, M. (2016). The Use of Dogs in Hospital Settings. [Online] Available at: <https://habricentral.org/resources/54870> [Accessed 1st August 2018].
- Royal College of Nursing (2018). A protocol to support organisations considering working with dogs in health care settings and allied environments. RCN. Available at: www.rcn.org/professionaldevelopment/publications/pdf-006909 [Accessed 1st August 2018]

If you have any suggestions for any interesting topics for future Journal Club articles just get in touch.

General Data Protection Regulation (GDPR)

In May 2018 a new data protection law was passed which affects all of us. This law primarily aims to protect all of our personal data from misuse or from being used without our knowledge or consent. Like any new law it can be confusing to know what to do and how it affects you and the work you do.

All NHS boards will have access to someone who is their GDPR controller. If you have any questions about GDPR in the first instance –contact them for advice. For more information see the Information Commissions Office website. www.ico.org.uk

We all use data and in our roles. We process data, some of which can be very sensitive such as medical records. Personal data is information that relates to an identified or identifiable individual. This could be as simple as a name, date of birth or could include other identifiers such as an IP address or CHI number.

Information which is truly anonymous is not covered by the GDPR. Information about a deceased person does not constitute personal data and therefore is not subject to the GDPR.

So what do you need to know?

The GDPR sets out seven key principles:

- Lawfulness, fairness and transparency – to prevent discrimination and to be clear about how data is being used.
- Purpose limitation –data cannot be processed for any reason other than the purpose it was intended for.
- Data minimisation – you can ask for your data to be restricted, e.g. opt out of receiving newsletters or publicity.
- Accuracy – you can ask for any inaccurate data to be removed or corrected.
- Storage limitation – prevents data being stored for a long time without being used for processing. There are some exceptions such as medical records have to be securely kept in case of future research in to a disease or if the person wishes to make a complaint or ask about a treatment they previously received.
- Integrity and confidentiality – for security data must be stored securely for example password protected or encrypted and if stored on paper it has to be locked securely when not being used or processed. It also has to be securely disposed of when no longer in use.
- Accountability – if you are using data you are accountable for how and why it is used. Any person can ask for all the data you hold about them to be removed. The new law sets strict time limits on when this must be done. You must respond to a request within one month.

Lawful basis: valid grounds for collecting and using personal data. There are six available lawful bases for processing. Which basis is most appropriate to use will depend on your data processing purpose and relationship with the individual.

1. **Consent:** the individual has given clear consent for you to process their personal data for a specific purpose.
2. **Contract:** the processing is necessary for a contract you have with the individual, or because they have asked you to take specific steps before entering into a contract.
3. **Legal obligation:** the processing is necessary for you to comply with the law
4. **Vital interests:** the processing is necessary to protect someone's life.
5. **Public task:** the processing is necessary for you to perform a task in the public interest or for your official functions, and the task or function has a clear basis in law.
6. **Legitimate interests:** the processing is necessary for your legitimate interests or the legitimate interests of a third party unless there is a good reason to protect the individual's personal data which overrides those legitimate interests. (This cannot apply if you are a public authority processing data to perform your official tasks.)

General Data Protection Regulation (GDPR) Continued

You need therefore to keep a record of which basis you are relying on for each processing purpose, and a justification for why you believe it applies. There is no standard form for this, as long as you ensure that what you record is sufficient to demonstrate that a lawful basis applies. This will help you comply with accountability obligations. Each health board will have a privacy policy to safeguard data protection. This should be freely available on websites, email footers or other prominent places within your organisation.

One of the important additional clauses for healthcare staff is:

'processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent'

The GDPR provides the following rights for individuals:

1. The right to be informed - the right to be informed about the collection and use of their personal data.
2. The right of access - Individuals have the right to access their personal data. This is commonly referred to as subject access.
3. The right to rectification - a right for individuals to have inaccurate personal data rectified, or completed if it is incomplete.
4. The right to erasure - a right for individuals to have personal data erased also known as 'the right to be forgotten'.
5. The right to restrict processing - the right to request the restriction or suppression of their personal data. This is not an absolute right and only applies in certain circumstances. When processing is restricted, you are permitted to store the personal data, but not use it.
6. The right to data portability - allows individuals to obtain and reuse their personal data for their own purposes across different services. To move, copy or transfer personal data easily from one IT environment to another in a safe and secure way, without affecting its usability.
7. The right to object - to object to the processing of their personal data in certain circumstances. Right to stop their data being used for direct marketing.
8. Rights in relation to automated decision making and profiling. - automated individual decision-making (making a decision solely by automated means without any human involvement) and profiling (automated processing of personal data to evaluate certain things about an individual). In other words "if the computer says no" you can ask for a review or decision by a human.

<https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/>

Stroke Improvement Workshop for Stroke Nurses

On Oct 3rd there will be a Stroke Improvement Workshop at Stirling Management Centre to examine how we as community stroke nurses can help to meet sections 7 and 8 of the Stroke Improvement Plan. The aim of the workshop is to look at how our roles can help to support patients to access information on resuming work, returning to driving, participating in exercise and helping them to self manage their stroke condition.

If this is part of your role then come along and join in. The day is free and further information is on the SSNF website on how to book a place.

These days are always invaluable and they make you examine your current practice, are an opportunity to share good practice and come away with new and innovative ideas. The SSNF highly recommends your attendance but if you cannot make it we will be Tweeting our opinions and comments. A report of the day will be available on the SSNF website after the event.

Stroke Rehabilitation Nursing

Two of the SSNF committee, Dr Maggie Lawrence and Linda Campbell have published a commentary and produced a podcast in Evidence-based nursing on the article Nurses and nursing assistants beliefs, attitudes and actions related to role and function in an inpatient stroke rehabilitation unit- A qualitative study by Loft et al, (Journal of Clinical Nursing 2017: 26:4905-4914).

The commentary looks at the implications for practice and research raised and concludes that education packages (such as the Stroke Core Competencies) should be a prerequisite for stroke unit staff induction programmes and that similar studies in other locations and contexts are required to fully understand the contribution of the nurses' role to stroke rehabilitation.

The podcast explores a series of questions about the content of the article and the opinions and conclusions of the commentary.

If you would like to read the commentary in full it is available online <https://ebn.bmj.com/content/21/2/44>

The podcast is available on <443393274-bmjgroup-nurse-education-in-stroke-rehabilitation-units.mp3>

CHSS Fundraising Craig Foreman 10K Funrun CHSS Fundraising



Craig Foreman Senior Charge Nurse, Lanarkshire NHS 'and the boys' completed a Men's 10K run in Glasgow on Sunday 17th June. The final total raised for CHSS was £2539.88. What a fantastic achievement.

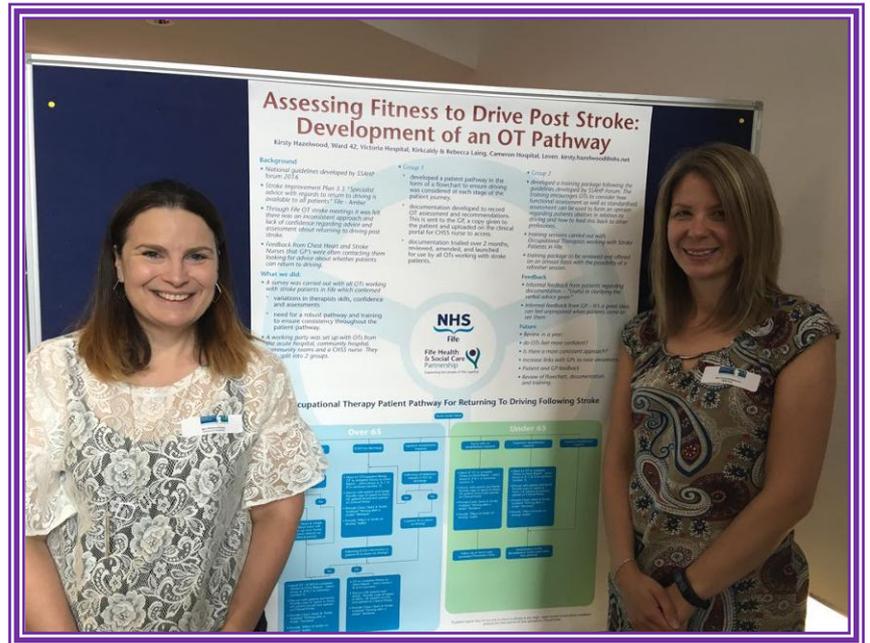


Presentation cheque to Jackie Gilmour (first on left) and Hazel Hamilton: April 2018, Lochgilphead

Staff at the police station held a police wellbeing event as one of their own staff had a stroke. They raised £120.10 and shared the money between CHSS and the Red Cross. The money was presented to Jackie (local Cardiac Nurse) and myself (Hazel) by the police inspector and one of the constables.

Driving

Kirsty Hazelwood and Rebecca Laing Occupational Therapists from Ward 42 VHK & Cameron Hospital presented a poster at the Scottish Stroke AHP Forum conference in Dundee on 13th June. The poster shows the work done by a working party of OT's in Fife following on from the guidelines developed by the SSAHP forum for returning to driving post stroke. A flowchart was developed to guide OT's on advice giving to patients and GP's at each stage of a patient's journey through stroke services in Fife. Documentation was developed with information to be recorded. Training was provided to OT's working with stroke patients on the pathway.



Assessing Fitness to Drive Post Stroke: Development of an OT Pathway

Kirsty Hazelwood, Ward 42, Victoria Hospital, Kirkcaldy & Rebecca Laing, Cameron Hospital, Leven. kirsty.hazelwood@nhs.net

Background

- National guidelines developed by SSAHP forum 2016
- Stroke Improvement Plan 3.3 "Specialist advice with regards to return to driving is available to all patients" File - Amber
- Through File OT stroke meetings it was felt there was an inconsistent approach and lack of confidence regarding advice and assessment about returning to driving post stroke.
- Feedback from Chest Heart and Stroke Nurses that GP's were often contacting them looking for advice about whether patients can return to driving.

What we did:

- A survey was carried out with all OTs working with stroke patients in Fife which confirmed:
 - variations in therapists skills, confidence and assessments
 - need for a robust pathway and training to ensure consistency throughout the patient pathway.
- A working party was set up with OTs from the acute hospital, community hospital, community teams and a CHSS nurse. They then split into 2 groups.

Group 1

- developed a patient pathway in the form of a flowchart to ensure driving was considered at each stage of the patient journey.
- documentation developed to record OT assessment and recommendations. This is sent to the GP, a copy given to the patient and uploaded on the clinical portal for CHSS nurse to access.
- documentation trialled over 2 months, reviewed, amended, and launched for use by all OTs working with stroke patients.

Group 2

- developed a training package following the guidelines developed by SSAHP Forum. The training encourages OTs to consider how functional assessment as well as standardised assessment can be used to form an opinion regarding patients abilities in relation to driving and how to feed this back to other professions.
- training sessions carried out with Occupational Therapists working with Stroke Patients in Fife.
- training package to be reviewed and offered on an annual basis with the possibility of a refresher session.

Feedback

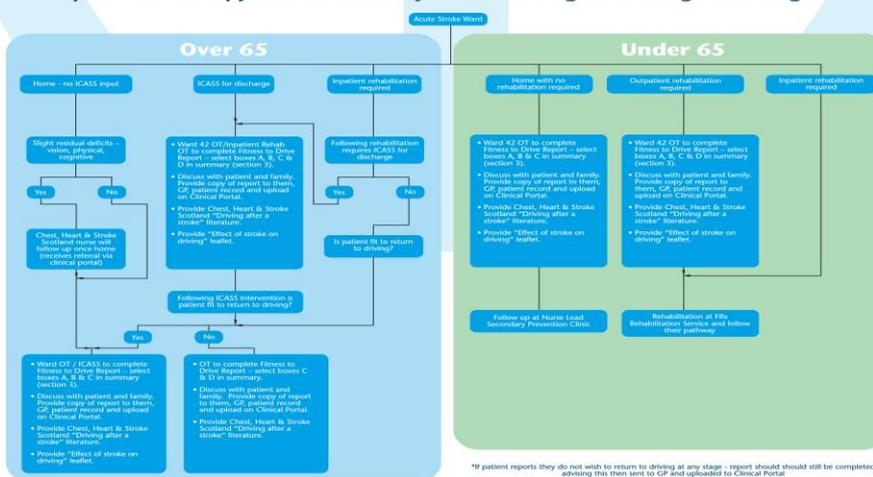
- Informal feedback from patients regarding documentation – "Useful in clarifying the verbal advice given"
- Informal feedback from GP – "It's a great idea, can feel unprepared when patients come to see them"

Future

- Review in a year:
- do OTs feel more confident?
- Is there a more consistent approach?
- Increase links with GPs to raise awareness
- Patient and GP feedback
- Review of flowchart, documentation and training.



Occupational Therapy Patient Pathway For Returning To Driving Following Stroke



*If patient reports they do not wish to return to driving at any stage - report should still be completed sending this then sent to GP and uploaded to Clinical Portal

