Introduction
The ‘Acute Stroke Unit’ consists of twenty eight beds, and the associated medical team is made up of four consultants, two SpRs, one FY2 and two FY1s. At any one time three consultants have their own patients on the ward whilst the fourth performs stroke liaison work. Dr. Crawford, Dr. Durward and Dr. Evans are elderly care consultants and Dr. Weir is a neurologist – all of the consultants specialise in stroke medicine. The SpRs share their time between clinics, ward work, and stroke thrombolysis assessments.

Many misconceptions surround the FY1 rotation on the ‘Acute Stroke Unit’. This is an acute unit and whilst rehabilitation co-exists on ward F8, it is not primarily a rehabilitation medicine ward. My medical experience in this role has been very general and I have learnt about many diseases alongside stroke, within a diverse patient population. The youngest patient on the ward during my placement has been 25. The rotation is challenging; the patients have high care needs, often with multiple co-morbidities. Many of the patients are acutely unwell. Patient turnover is also high; patients are discharged to rehabilitation units and the beds quickly re-filled.

Stroke medicine is very multidisciplinary and I have been well supported throughout this placement. The ward Sisters - Sue, Collette and Donna have been a great source of advice.

Jobs throughout the Day
The day starts at 8:30am; as we currently do not have a phlebotomy service, we do a venesection round. The patient list is then updated. There are a high number of fasting bloods to be done for stroke secondary prevention. The patient in need of fasting is written, by the FY1, on the white board the day before. At 9am one of the FY1s attends Dr. Bodaghs hand over meeting in the G level seminar room. The second FY1 and usually the SpR will have a short meeting with one of the senior sisters in order to discuss any concerns they have about patients. These issues then need to be raised and addressed on the ward round. I have found this is more time efficient. It results in fewer interruptions during the ward round and means that the nurses’ concerns are addressed early on. One FY1 will then go on a consultant ward round (there is normally one each day) and the other will go with the SpR to see the other consultants patients. Usually, the ward round
Job Description from a FY1 Trainee’s Point of View.

Finishes before 12pm. During the morning it is important to try and complete any HMRS (or at least the TTO sections for the pharmacist to sort), or death certificates. Sue Gilbert, the discharge co-ordinator nurse, organises discharges.

There is a ‘non-urgent doctors jobs’ book on the main desk and it helps the nursing staff if these jobs can be addressed following the ward round and at the end of the day. Many of the patients find it difficult to swallow and require nasogastric tube (NGT) feeding. Jobs like requesting and checking CXRs for NGT tip placement, if nursing staff cannot get aspirate, are commonly written in the book.

Breaks for both lunch and teaching are important. In my experience, providing one of the senior sisters knows you will be off the ward for teaching, they will protect your teaching time. It can also be quite useful to attend some of the multidisciplinary team meetings the consultants have at lunch. On Mondays, there is a radiology meeting where patients scan results are discussed, this is also useful to attend.

In the afternoon, I would usually perform the jobs from the ward round. You get a lot of experience discussing cases with radiology as a great number of MRI head, and CT head, scans are requested. Blue forms in the front of a patient’s notes, detailing the dates and times certain investigations are performed, need to be filled out for auditing purposes. You will also make numerous requests for other teams to review patients. We sometimes find a patient has significant carotid stenosis following, carotid dopplers and the FY1 will need to fill in a ‘fastrack vascular referral form’ available on the doctors desk. Unfortunately, we currently suffer from a lack of medical assistant support and numerous patients require cannulas, and male patient’s catheters. There are some nurses on the ward who can perform male catheterisation and one nurse who can cannulate, so try asking around, otherwise these jobs fall to the FY1 to complete. Most of the request cards you will need are in the draws by the doctor’s desk.

At the end of the day, the team has found it helpful to go through the patient list together discussing jobs done and those still pending. This helps us get to know all of the consultants’ patients (you may be on different consultant ward rounds each week). The patient list requires updating at the end of the day. Blood forms need to be put in the blood box on the doctor’s desk for the following day. On Fridays, weekend handover sheets need to be written and put in the patient’s notes.

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Survival Tips
This is a multidisciplinary unit; it is important to fit in and work as part of the team. The nursing staff, physiotherapists, occupational and speech and language therapists and dieticians have years of experience with stroke patients.

There are a lot of misconceptions about stoke medicine; try and approach the job with an open mind.

This is a challenging and busy role. However, there are plenty of people to ask if you are stuck. Make sure you take breaks.

Complete HMRs and death certificates as early as possible.

Not all drugs can be delivered through an NGT. The senior sisters and ward pharmacists can offer a lot of advice on suitability.

The consultants are very approachable should you find you have a problem. I have found this an enjoyable and rewarding rotation. I am sure you will too.