

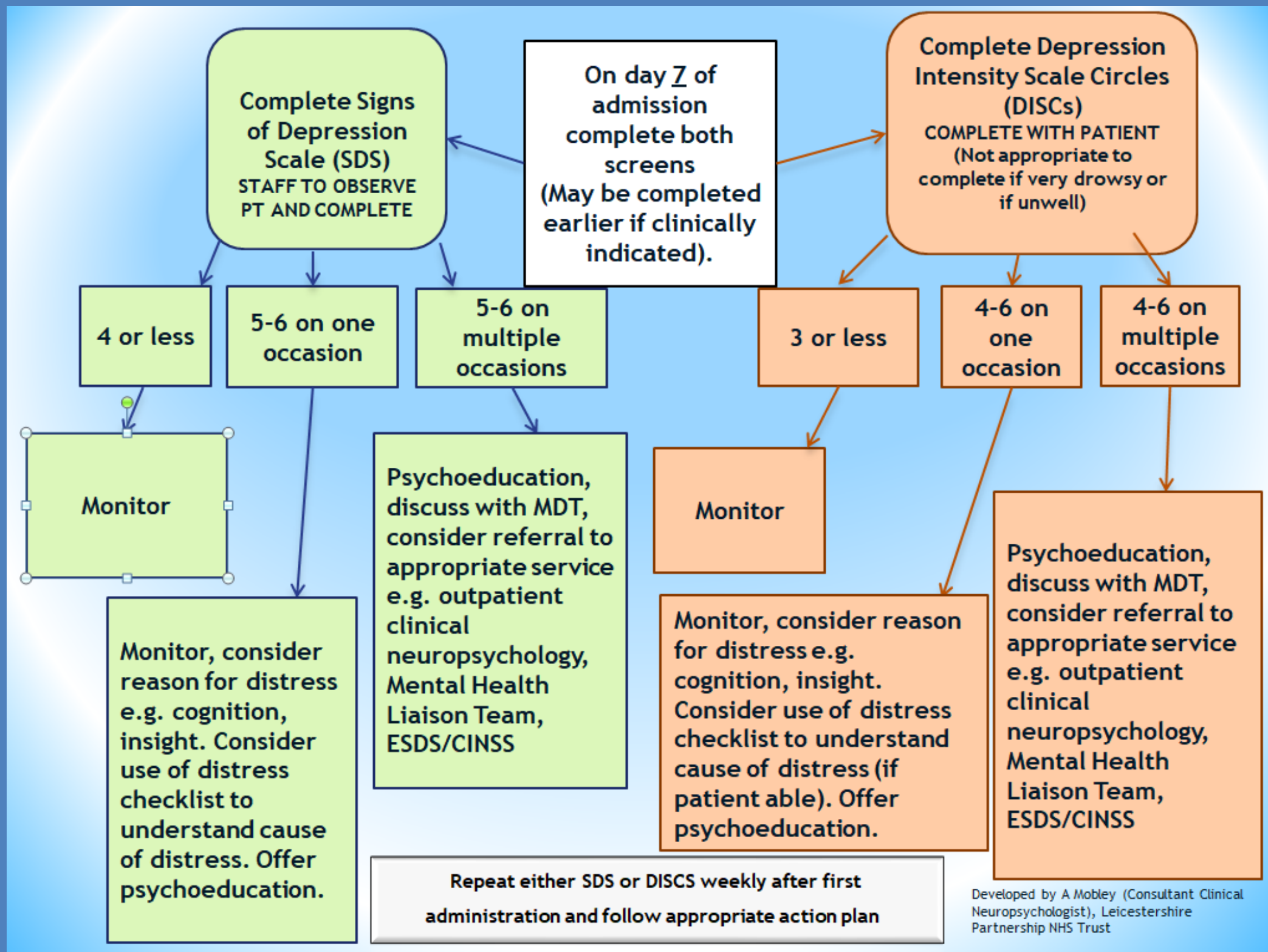
Background

Mood disturbance is very common after stroke;
- 1/3 of people experience depression after stroke
- 1/4 experience anxiety

National guidelines recommend that mood should be screened with every stroke patient at least once during their acute phase of rehabilitation (within 6 weeks). Further assessment should be completed at transfer to post -acute services and at 6 and 12 months.

In UHL, OTs ask new stroke patients on ASU about their mood prior to stroke but there is currently no routine formal process for screening mood after stroke in the acute phase for in-patients. Clinical neuropsychology is also not currently accessible for in-patients on the stroke care pathway in Leicestershire.

To improve mood screening in acute stroke, a mood screen pathway was developed by a Consultant Clinical Neuropsychologist, using both a staff reported (observational) measure and a patient reported measure.



Signs of Depression Scale (SDS) – a staff reported measure	
1) Does the patient sometimes look sad, miserable or depressed?	Yes/No
2) Does the patient ever cry or seem weepy?	Yes/No
3) Does the patient seem agitated, restless or anxious?	Yes/No
4) Is the patient lethargic or reluctant to mobilise?	Yes/No
5) Does the patient need a lot of encouragement to do things for him/herself?	Yes/No
6) Does the patient seem withdrawn, showing little interest in doing things?	Yes/No

(<https://journals.sagepub.com/doi/epub/10.1177/0269215517708328>)

Depression Intensity Scale Circles (DISCs)

5 ● Most Severe Depression

4 ●

3 ●

2 ●

1 ●

0 ○ No Depression

A self-reported screen - aphasia friendly

Aim:

To pilot a mood screening pathway on an acute stroke ward (ward 26, LRI) for 12 weeks.

Objectives:

- 1) 100% of acute stroke patients on ward 26 admitted for 7 days or longer will be reviewed for mood screening
- 2) An action plan will be documented for all patients where a mood screen has been completed.

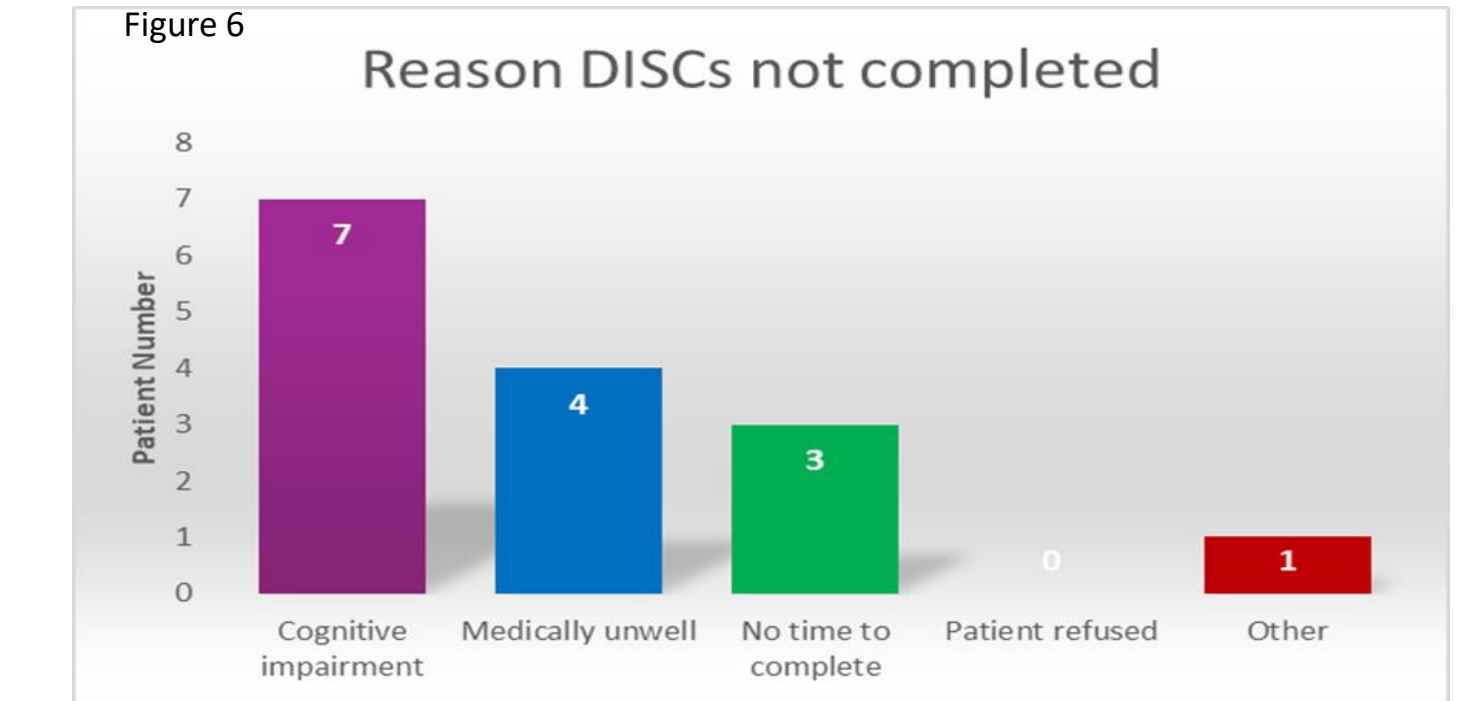
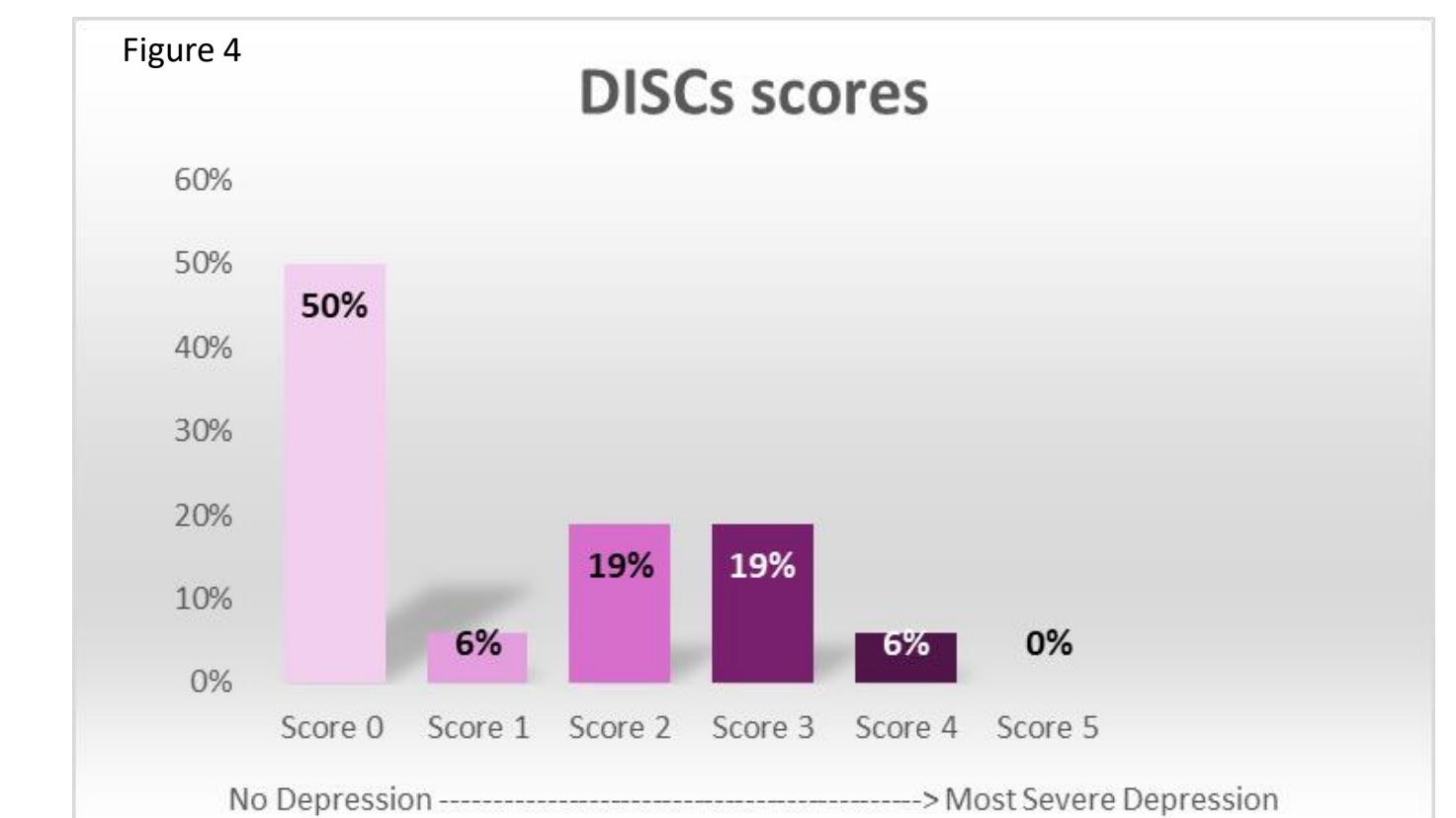
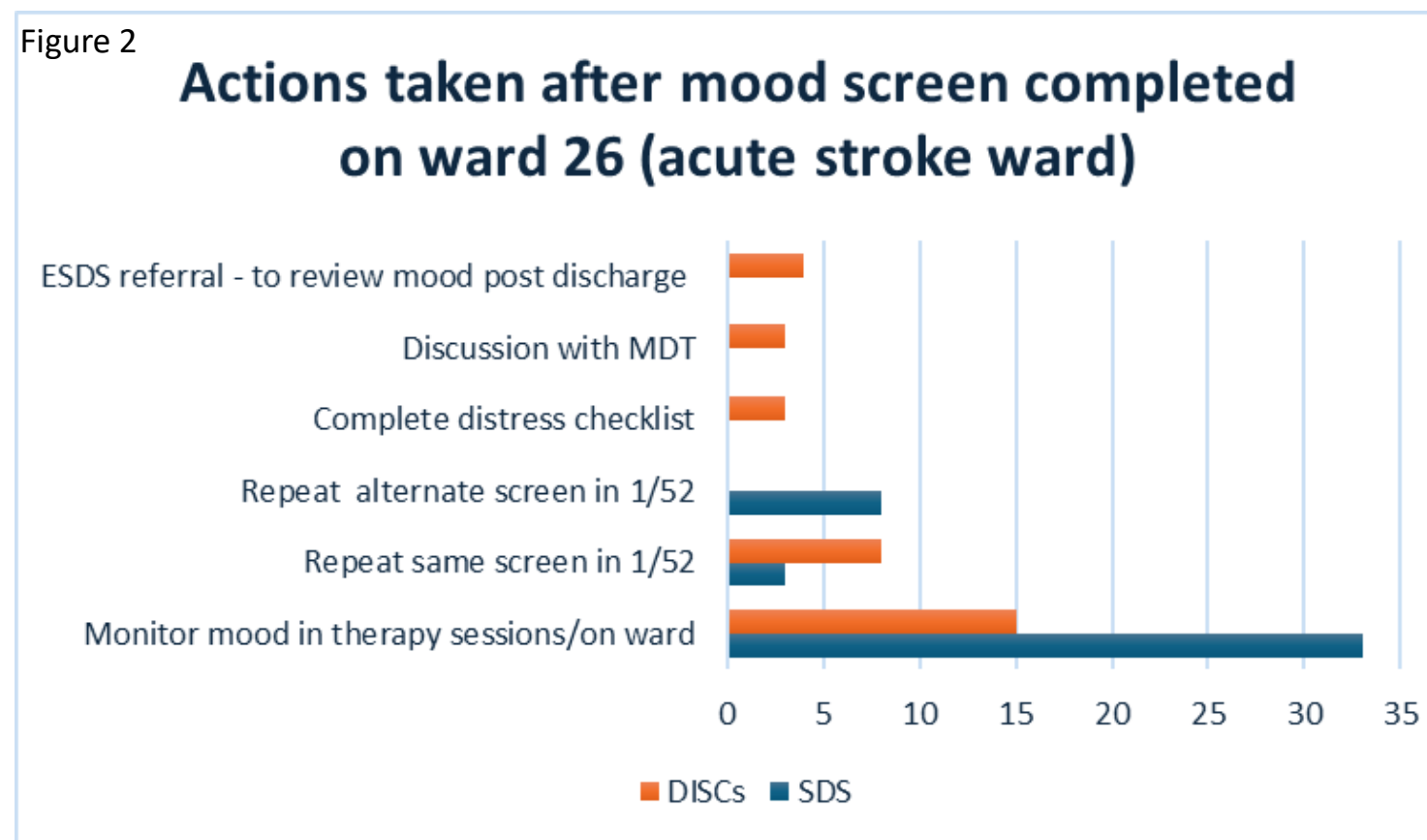
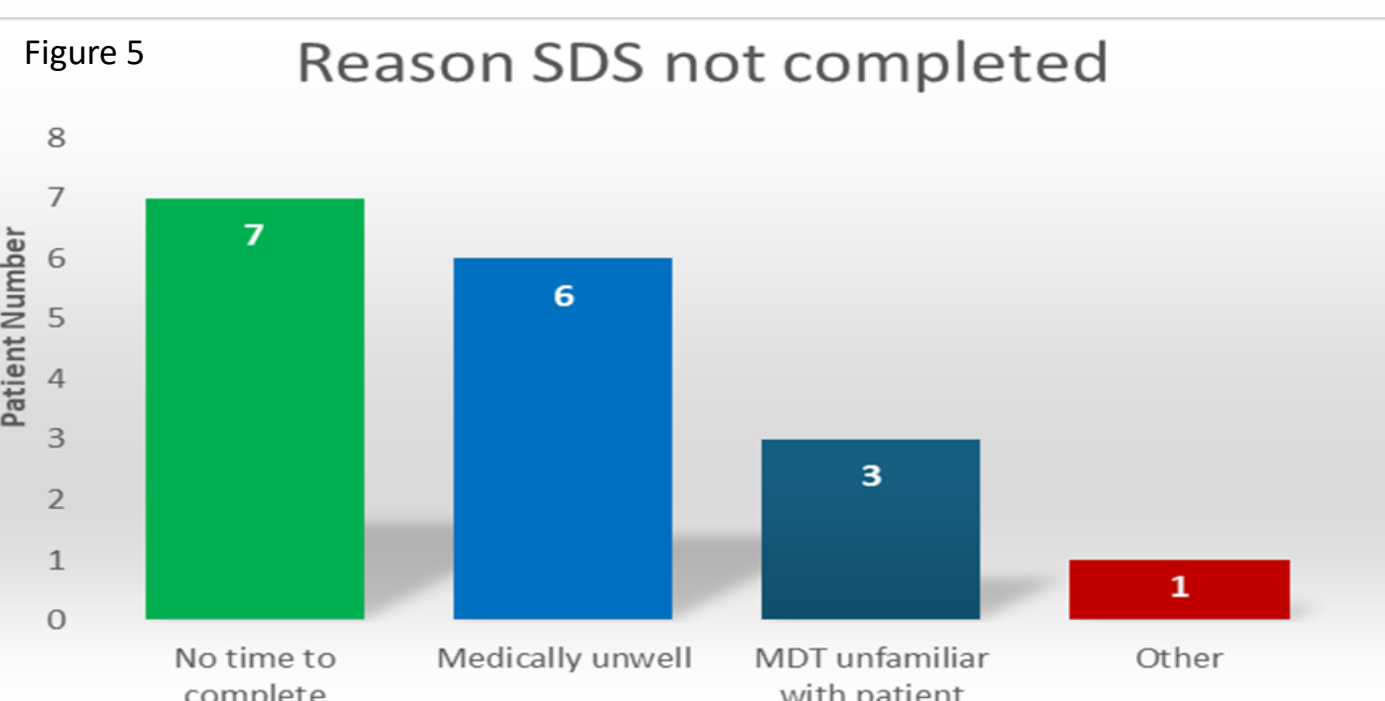
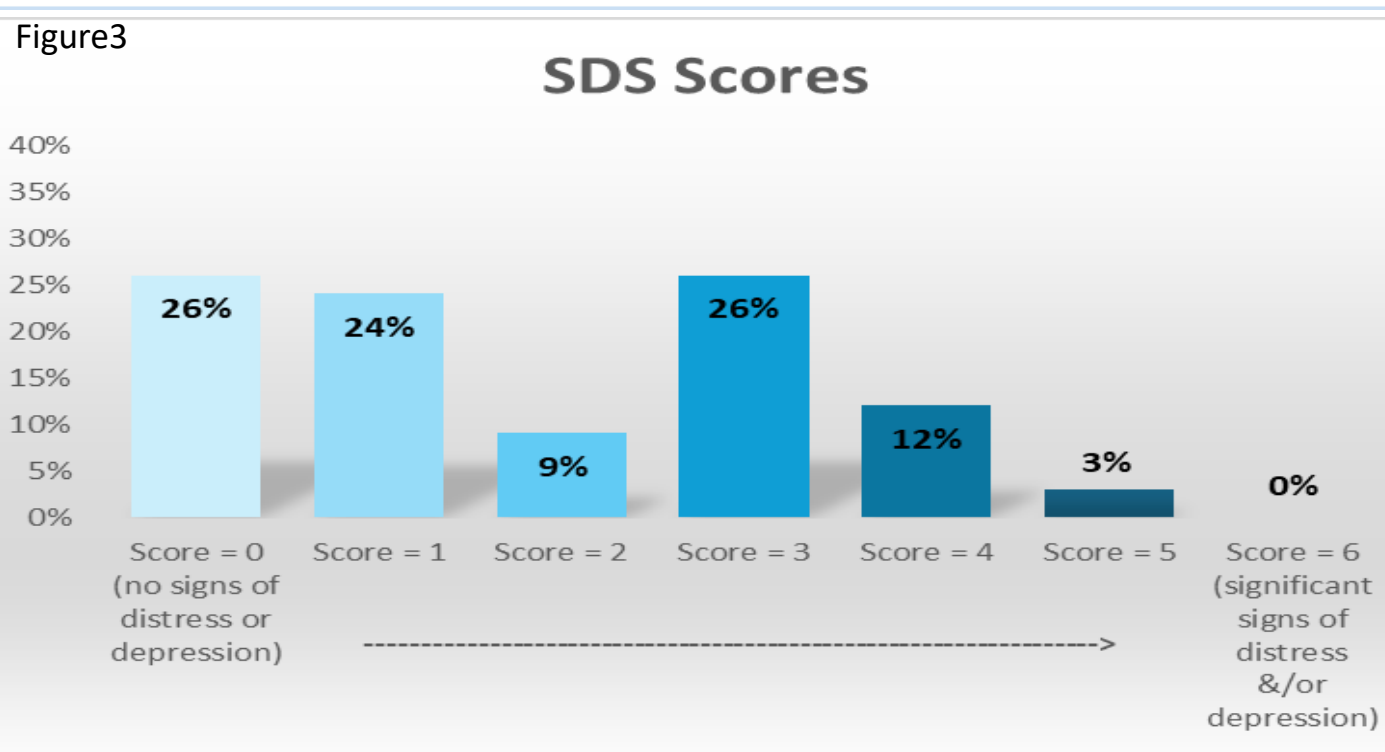
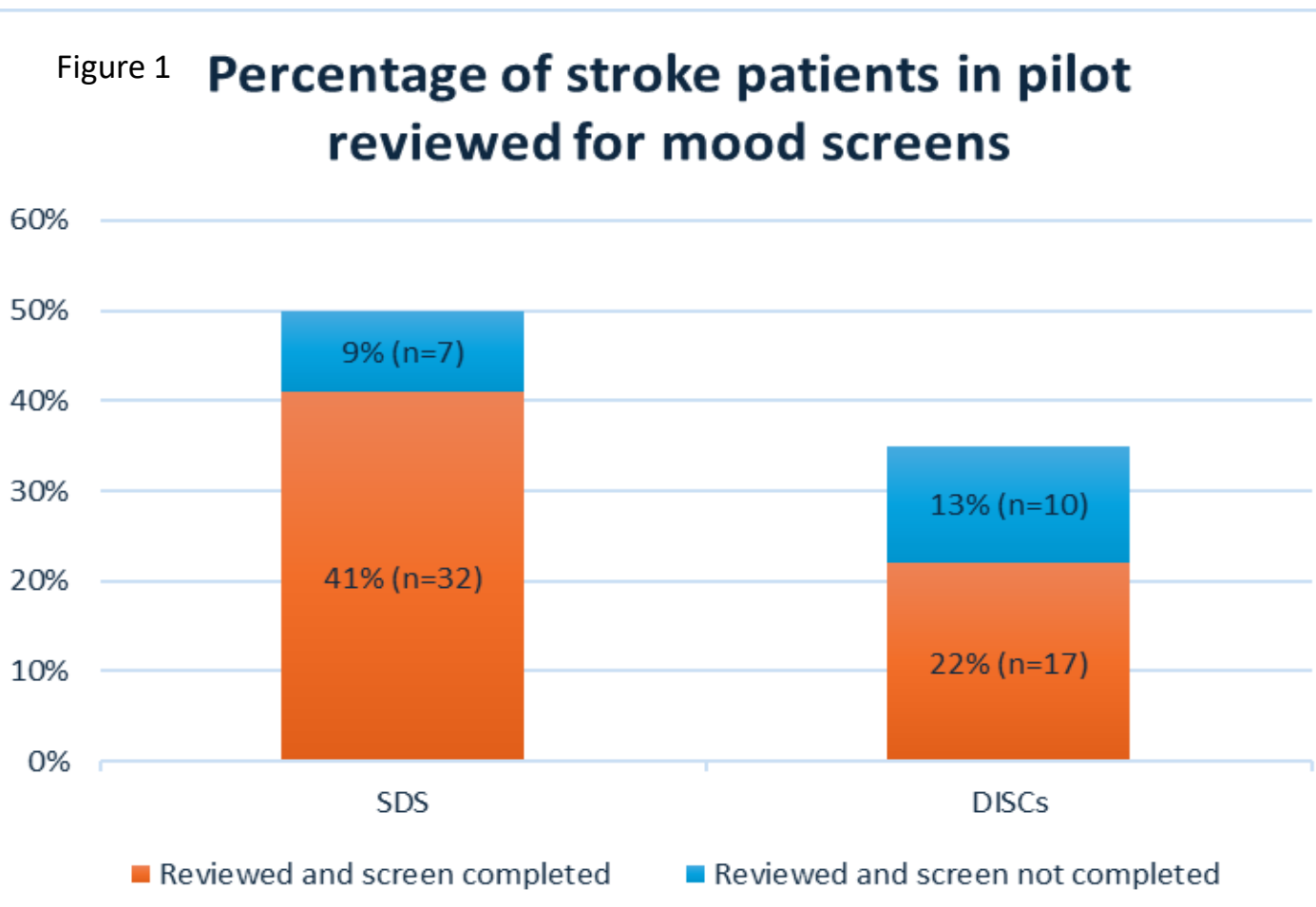
Method

- Pilot period 16/07/23 – 07/10/23
- Inclusion Criteria: Patients identified with diagnosis of acute stroke admitted onto acute stroke unit for 7 days or longer.
- SDS completed by OT with input from MDT at daily board round
- DISCs completed with patients during OT therapy sessions
- Both SDS and DISCs were completed from day 7 of admission with action plans identified and documented
- Either SDS or DISCs repeated weekly by OT as needed.
- Audit data collected in real time using SSNAPPY
- Discussions completed with participating OTs and members of the MDT for feedback on the mood screening process.

(Screening in the first few days after stroke is likely to be an unreliable measure of mood (NHS Improvement – Stroke, 2018) , therefore stroke patients admitted for 7 days or less were excluded from mood screening unless clinically indicated.

Results

- Number of stroke patients meeting criteria for mood screen during pilot period = 78
- 51% of these patients were reviewed for a mood screen (39 reviewed for SDS and 27 for DISCs). See Figure 1.
- Figure 5&6 shows reasons mood screens were delayed or not completed
- 100% of patient screened had an action plan documented. Figure 2 shows breakdown of actions taken.
- Figure 3 & 4 show distribution of mood screen scores. Some disparity noted between results of SDS and DISCS completed with individual patients (5 patients with SDS scored 0-1 and DISCs scored 2-4).



Qualitative Feedback Included

- Provided opportunity to have early conversations about the psychological impact of stroke
- Sets a measure of patient's mood at start of stroke recovery journey
- Dedicated time needed
- Queries raised regarding sensitivity of SDS as a screening tool in the acute stage for large strokes.
- Challenging to complete SDS in board round due to time pressures and lack of familiarity of patients by ward staff present
- Mixed feedback from post acute rehabilitation wards as to whether completion of mood screens on acute wards influenced their practice.
- More training required on managing conversations related to mood and anxiety and on psycho-education techniques

Conclusion

Objective 1 – not achieved. Objective 2 – achieved. Embedding a mood pathway into daily clinical practice without inpatient neuropsychology input or additional resources, training or staffing is challenging and although an increase in mood screening was achieved it was significantly below target.

The main reasons preventing a greater number of screens being recorded include:

- Low staffing (OTs) – often only one OT on the ward..
- Incomplete data recording
- Weekend working/ rotational staff not familiar with process
- Speed of patient flow through acute ward

The pilot highlighted that it is not feasible for OTs alone to complete all mood screens. It requires shared responsibility with the MDT .

Results also highlight need to prioritise use of patient self-reported measures over staff reported measures. A review of the screening tools used is also indicated.

Next steps include wider MDT discussion in acute stroke to determine how to proceed with mood screening based on results and feedback received

Recommendations .

- Regular staff training, provided by neuropsychology, to ensure MDT staff feel competent in mood screening and in their role providing psychological care for patients on the ward
- Incorporation of appropriate mood screening tools into stroke proformas for relevant wards
- Wider review and /or development of Leicestershire in-patient stroke pathway to screen and manage psychological impact after stroke in line with National Stroke Guidelines