Cardiac & Stroke Networks LANCASHIRE & CUMBRIA

NHS

Cardiac and Stroke Networks in Lancashire & Cumbria

University Hospitals of Morecambe Bay NHS Trust

Furness General Hospital

Peer Support Visit 25 January 2010

Feedback Report

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Background

University Hospitals of Morecambe Bay NHS Trust (UHMBT) serves a population of 310,000 (NHS North West, Emergency Care Review July 2009) and comprises three sites: Furness General Hospital, Royal Lancaster Infirmary and Westmorland General Hospital.

Furness General Hospital serves a population of approximately 110,000 and medical services are commissioned by NHS Cumbria; Social Service input to the Trust and community comes from Cumbria County Council.

The hospital admits approximately 170 patients with stroke per year. Stroke patients will usually be admitted via the Emergency Department (ED) or Medical Assessment Unit (MAU) and then transferred to the Acute Stroke Ward (Ward 6). The stroke service at Furness has undergone an enormous amount of change over the last 12-18 months with the re-designation of a ward for acute stroke and stroke rehabilitation. The stroke services are led by Dr Alan Barton and Dr Gill Cook, and a stroke team has been set up to improve the service for patients. The team includes representatives from all departments. Stroke champions have been established in A&E and on the ASU. The team at Furness are working to commence a day-time thrombolysis service for acute ischaemic stroke and develop direct admissions to the stroke ward.

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Introduction

A team from the Cardiac and Stroke Networks in Lancashire & Cumbria visited Furness General Hospital (FGH) on 25 January 2010. The purpose of the visit was to allow exchange of good practice between various departments and Trusts within the Network. The team visiting FGH included a Consultant Physician/Clinical Lead for the Stroke Network, an Occupational Therapist, a Speech and Language Therapist, a Community Stroke Rehabilitation Team Leader, an A&E Manager, a CVD Commissioning Lead, a representative from The Stroke Association, Service Managers and Service Improvement Managers, representing eight organisations within the Stroke Network.

The day comprised meetings with the Medical Director, service managers and clinicians from UHMBT and local Social Services and then visits to all departments in the Trust which have input to the stroke patients' journey. In addition, members of the visiting team met with representatives of the Community services which input to stroke care. The day concluded with a feedback session to representatives of the Trust, including members of those departments visited during the day.

All involved in the visit valued the warm welcome that was extended to us by the staff at FGH and were impressed with the individuals who provide the care in all the departments visited. We were provided with self-completed questionnaires from each department visited prior to the day which informed the team of the service currently in place, this report is based on the information from the questionnaires, meetings and feedback that the team had during the day.

We hope that the report will be helpful to the team at Furness General Hospital in further developing their services.

National Sentinel Audit Results

The National Sentinel Audit is completed in alternate years and the last iteration was in 2008. During the last round of the audit there was 100% participation by hospital Trusts. This has allowed benchmarking of services compared to standards set in the Royal College Guidelines for the management of stroke. The audit is in two parts; organisation and process, Organisational measures include for example the number of stroke beds, direct admission to a stroke unit, the provision of thrombolysis as well as composition of stroke teams.

Clinical processes are measured through a retrospective review of the notes of the first 60 patients admitted with stroke from April 2008.

	UHMBT/FGH	**National Average**
Organisation (%)	61 (2009)	73
Clinical Process (%)	57	70
9 key indicators	58	71.5

Sentinel Stroke Audit

- 90% Stroke Unit Median score 56.3 FGH32
- Swallowing Median score 73.3 FGH 50
- Scan 24 hours Median score 57.3 FGH 51
- Aspirin Median score 88.3 FGH 41
- Physio Median score 88 FGH 86
- OT Median score 69 FGH 64
- Weighed Median score 75.7 FGH49
- Mood Median score 67.8 FGH 66
- Rehab goals Median score 91.8 FGH 80
- Overall Median score 71.5 FGH 58

National Sentinel Audit Results for Organisation- for Trusts within the Network

Table 2: Summary of key organisational results by hospital including waiting time for scan, presence of neurovascular/TIA clinic and involvement with patients

Site name (name of trust or hospital within a trust)	Average CT scan waiting time weekdays	Average CT scan waiting time weekends	Average MRI scan waiting time weekdays	Average MRI scan waiting times weekends	Neurovascular clinic	TIA Service	Neurovascular clinic average waiting time	All high risk TIA patients seen and investigated within	All low risk TIA patients seen and investigated within	Patient/carer views sought on service	Report produced within 12 months analysing	Overall position in 2008	Overall position in 2006
Blackpool Fylde & Wyre Foundation Trust	5-24 hours	25-48 hours	>48 hours	>48 hours	Yes	Yes	14	No	No	No	No	◆	✗
East Lancashire Hospitals NHS Trust	5-24 hours	>48 hours	>48 hours	>48 hours	Yes	Yes	10	No	No	Yes	Yes	✗	N/A
LTH Foundation Trust – (Chorley)	25-48 hours	>48 hours	>48 hours	>48 hours	Yes	Yes	14	No	No	Yes	No	✗	✗
LTH Foundation Trust – (Preston)	5-24 hours	>48 hours	25-48 hours	>48 hours	Yes	Yes	10	No	No	Yes	No	◆	◆
UHMBT – Furness General Hospital	5-24 hours	25-48 hours	25-48 hours	>48 hours	Yes	Yes	7	No	No	No	No	◆	◆
UHMBT – (Royal Lancaster Infimary)	5-24 hours	5-24 hours	25-48 hours	>48 hours	No	Yes	N/A	No	No	No	No	✗	✗
UHMBT – (Westmorland General)	5-24 hours	25-48 hours	25-48 hours	>48 hours	Yes	Yes	2	No	No	No	No	✗	◆
NCA – (Cumberland Infirmary)	0-4 hours	5-24 hours	5-24 hours	25-48 hours	Yes	Yes	5	No	Yes	Yes	No	◆	◆
NCA – (West Cumberland)	0-4 hours	5-24 hours	25-48 hours	>48 hours	Yes	Yes	0	Yes	Yes	Yes	Yes	✓	✓

This table includes average estimated waiting times for scans, whether the trust has a neurovascular/TIA clinic and involvement with patients. The total organisational score is an aggregated score across all domains. The best organised 25% of hospitals are in the upper quartile designated by the symbol √, the least well organised hospitals for stroke care are in the lower quartile designated with the symbol ✗, the middle half lie between the two designated by the diamond ◆

Key: **Upper Quartile** (green) **Middle Half Interquartile Range** (peach) **Lower Quartile** (red)

The process audit can be summarised by analysing the “nine key process indicators”. Scores for these key indicators correlate well with the total audit score.

Table 3: The 9 key indicators for all hospitals

Site name (name of trust or hospital within a trust)	Number of cases in the audit	Screening for swallowing disorders <24 hours after admission (%)	Brain scan within 24 hours of stroke (%)	Physiotherapist assessment within 72 hours of admission (%)	Occupational therapy assessment within 4 working days of admission (%)	Patient weighed during admission (%)	Patient’s mood assessed by discharge (%)	Rehabilitation goals agreed by the multidisciplinary team (%)	Aspirin or clopidogrel by 48 hours after stroke (%)	Patients spent at least 90% of stay on a stroke unit (%)	Percentage of eligible patients receiving all 9	Overall position in 2006	Overall position in 2008
National Results %	(11369)	72%	59%	84%	66%	72%	65%	86%	85%	58%	17%		
Network Results %		65%↓	48%↓	76%↓	45%↓	58%↓	54%↓	79%↓	80%↓	54%↓	6%↓		
Blackpool Fylde & Wyre Foundation Trust	(58)	50	32	84	24	61	58	69	90	77	0		
East Lancashire Hospitals NHS Trust	(62)	72	55	80	66	64	11	48	87	62	0	N/A	
LTH Foundation Trust – (Chorley)	(40)	44	16	29	42	41	35	55	35				
LTH Foundation Trust – (Royal Preston)	(51)	72	71	66	33	62	91	92	82	52	19		
UHMBT – Furness General Hospital	(42)	50	51	86	64	49	66	80	41	32	0		
UHMBT – Royal Lancaster Infirmary	(63)	67	54	73	43	17	35	90	92	53	0		
UHMBT – Westmorland General Hospital	(20)	89	0	73	0	65	56	91	100	100	0		
NCA – Cumberland Infirmary	(59)	67	53	85	75	81	76	96	93	62	20		
NCA – West Cumberland	(53)	79	65	89	31	86	65	97	91	58	11		

Key: **Upper Quartile** **Middle Half Interquartile Range** **Lower Quartile**

Above National %	↑
Below National %	↓

Overview of the Furness General Hospital Stroke Pathway

Patients are admitted as emergency cases either by self referral or from their General Practitioner. The desired pathway is for patients to be transferred rapidly from the Accident and Emergency Department to the CT scanner and thence to the Stroke Ward 6.

There is no stroke thrombolysis service available in the Trust at present.

A&E Department

Visiting group:

Paul Davies – Consultant Stroke Physician, North Cumbria University Hospitals NHS Trust & Network Clinical Lead
Michael Dudley – Matron, A&E Department, Lancashire Teaching Hospitals NHS Foundation Trust
Natalie Park – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Beverly Drake – Assistant Service Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

We were impressed by our visit to the Accident and Emergency (A&E) department. There was a clear knowledge about stroke and the stroke developments and the team felt involved by all the changes. The stroke champion in A&E had clearly been involved in training other staff and keeping them up to date. A&E Receptionists had been trained in using the FAST test. A Stroke awareness notice board was present. Nurses and doctors were trained in the ROSIER and pocket cards with the ROSIER scale were available.

Patients are generally brought to A&E by ambulance. The pre-alert system is currently quite patchy.

Patients with suspected stroke were prioritised and moved to the emergency area. Medical referrals were made and requests for CT scan before the patients moved to the ward. Stroke pathways and protocols were available. Currently most patients are transferred to the Medical Admissions Unit with only a few going straight to the stroke unit from A&E.

Patients presenting with TIA were assessed, high risk TIA patients were admitted to the Medical Admission Ward; low risk TIA patients are discharged and seen the next working day in a TIA clinic. The A&E staff were aware of the ABCD2 risk stratification score.

A number of staff mentioned the new electronic notes system called Lorenzo. There were concerns that some of the processes within Lorenzo might slow up the process of care for stroke patients. One example was that Lorenzo may only allow Consultants to order CT head scans, it was suggested that currently staff grade and registrar grade doctors request CT head scans and waiting for a Consultant may slow things down.

The team were aware of the plans for day-time thrombolysis at FGH and were enthusiastic about the service starting. They acknowledged that the number of patients thrombolysed on the site will be small but their training needs will be the same as anywhere else. The current plan for patients who are to be thrombolysed for acute ischaemic stroke is to monitor patients in A&E during thrombolysis and then the patient is to be transferred to the High Dependency Unit (HDU) but there are concerns about having adequate staff to cover thrombolysis as a 24 hour service.

Examples of good practice

- Receptionists – FAST trained
- Pocket size ROSIER info cards available
- Staff Nurse – Stroke champion (STAT training, ROSIER & FAST training)
- Algorithms produced for Bed Management Teams
- Very good access to CT (next available slot)

Recommendations

- Continue training all staff in stroke recognition and thrombolysis for acute stroke
- Plan for staffing requirements for Telestroke (out of hours thrombolysis)
- Ensure that Lorenzo works for stroke patients rather than stroke patients having to fit to the requirements of Lorenzo.

Imaging

Visiting Group:

Paul Davies – Consultant Stroke Physician, North Cumbria University Hospitals NHS Trust & Network Clinical Lead
Michael Dudley – Matron, A&E Department, Lancashire Teaching Hospitals NHS Foundation Trust
Natalie Park – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Beverly Drake – Assistant Service Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

The department is perfectly situated next door to the A&E Department. The department is able to perform CT Head scans (emergency out of hours), MRI head scans (working day only) and carotid imaging (working day).

Access to CT head scans during the working day is excellent. They are performed as soon as the department knows about them. A recent audit showed 80% of patients are having CT head scan within 24 hours. Out of hours CT head scans are available for those that require them urgently and will be available for out of hours thrombolysis. The staff requested time of onset of stroke should be put on the request cards to help them prioritise stroke patients that are not scanned on admission.

The TIA clinic works as a one-stop clinic and same day Carotid Ultrasound and CT head scan are available. MR imaging for TIA is more difficult to obtain because of capacity issues.

We were made aware that the Trust is exploring a “cross-bay” on call rota with images transferred to an on-all Radiologist at one of the sites of the Trust. This would not affect the Telestroke project.

When asked, staff suggested that additional portering time would help with transfers of patients and nurse escorts from the wards would be appreciated with patients who are drowsy or have language problems.

Examples of good practice

- Excellent access to CT head scans for stroke patients
- Excellent access to both CT head scans and Carotid Ultrasound for TIA patients.
- Good links with A&E

Recommendations

- To explore whether additional portering time would lead to more efficiency
- To develop MRI scanning for TIA and stroke in line with the National Stroke Strategy
- Aim for a seven day service
- Time of onset of stroke to be recorded on request cards to help them prioritise stroke patients eligible for thrombolysis.

Medical Assessment Unit (MAU)

Visiting group:

Paul Davies – Consultant Stroke Physician, North Cumbria University Hospitals NHS Trust & Network Clinical Lead
Michael Dudley – Matron, A&E Department, Lancashire Teaching Hospitals NHS Foundation Trust
Natalie Park – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Beverly Drake – Assistant Service Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

The Medical Assessment Unit is the first destination of patients admitted with any medical problem. Patients may be referred directly from a GP or be referred from A&E. Stroke patients comprise a small proportion of the daily intake. The MAU has 21 beds and is in close proximity to A&E. A combined CCU and HDU is situated on level 6 in close proximity to the stroke ward. The unit is staffed by a physician for the day, a registrar, an F1 and an F2 doctor. Some beds on the MAU are monitored.

Stroke patients may already be on a stroke pathway if they have been transferred from A&E. Those stroke patients admitted directly to MAU are started on a pathway, which is stipulated in the algorithm generated for stroke patients not on the Acute Stroke Unit (ASU).

Patients are assessed by the junior doctors and CT head scans requested.

Most patients are transferred to the Acute Stroke Unit within 24 hours of admission.

Patients with minor stroke or TIA who improve rapidly can access physiotherapy on MAU but there is currently no OT input.

Staff did raise concerns that there are only a few staff trained in performing swallowing assessments on MAU. Training has been provided by Ward 6 staff on how to use the stroke pathway.

Examples of good practice

- Good level of medical staff
- Close proximity to A&E
- Most stroke patients transferred to ASU within 24 hours
- Algorithm available to inform staff of stroke patient requirements

Recommendations

- Ideally, stroke patients should be admitted directly to ASU and omit this step in the pathway where possible.
- More nurses to undergo dysphagia training, (Speech and Language Therapy (SLT) training has been seen as a priority and extra training has been purchased that MAU can access.)

Community Stroke Team – Croslands Day Hospital

Visiting group:

Jeannie Hayhurst - CVD Commissioning Lead, NHS Blackpool
Chris Larkin – Deputy Regional Manager (North West), The Stroke Association
Kay Smith – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Tracy Walker – Community Stroke Rehabilitation Team Leader, NHS Blackburn with Darwen

Croslands Day Hospital is on the same site as the acute hospital. It provides accommodation for the TIA clinic and for stroke rehabilitation following discharge from hospital.

The day hospital is open five days per week between 8.30 am and 5.00 pm. Not all patients arrive on hospital transport, only around 50%. Patients for rehabilitation may attend between one and three sessions per week. TIA attendee's arrive at 8.30 am so that all investigations can be done in the morning. The rehabilitation provided is not exclusive to stroke patients, who make up about 50% of those attending. One of the staff has received stroke training, but most of the staff have worked in Rehab for a number of years.

Rehabilitation in the Day Hospital is staffed by a Physiotherapist (full time Band 6) who has specialised in neuro-rehabilitation, but there is no Occupational Therapy input. The lack of neuro-OT input means that there is little assessment of cognitive/perceptual functioning following discharge from the acute unit. Furthermore, advice on return to work, driving and leisure activities will not be assessed. Speech and Language Therapy can be accessed as required, as can dietetics advice.

Access to the Stroke Association Family and Carer support workers is available at the Day Hospital; stroke specific literature is readily available. Patients spend long periods of time waiting for transport no organised activities available for psychological stimulation.

The TIA clinics occur each weekday and have very good links for imaging enabling a "one-stop" visit. Patients requiring Carotid surgery are transferred to Lancaster. A robust system for data collection so that "Vital Signs" monitoring reports can be made is required. Timely referral from GPs is an issue and no standardised ABCD2 referral form is available, therefore achievement of Vital Signs targets will not be met.

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The visiting group identified:

Other Community Rehabilitation for stroke patients

- STINT (Short Term Intervention Team). This is a generic intermediate care team that can provide short-term rehabilitation in the patient's own home.
- Maple Unit. Provides intermediate care beds and nursing care in two units (one in Barrow and one in Millom). Generic rehab available OT, Physio.
- There is no Specialist Early Supported Discharge Team for stroke patients.

Examples of good practice

- The team at Croslands were well motivated and enthusiastic
- One-stop TIA clinic five days per week
- Stroke Association Family & Carer Support available

Recommendations

- Need to develop Specialist Early Supported Discharge Team for stroke patients in line with National Stroke Strategy and RCP Guidelines
- Need to establish neuro OT input into stroke rehabilitation following discharge
- Need to provide cover for therapists for annual leave/study leave.
- Introduce TIA referral form for GPs and raise awareness with Primary Care
- Transfer of care document needs to be developed and implemented
- Investigate voluntary services to provide organised activities for patients awaiting transport and other services.

Occupational Therapy

Visiting group:
Elaine Day – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Karen Waywell – Occupational Therapist, Blackpool, Fylde & Wyre Hospitals NHS Foundation Trust
Jan Huddleston – Speech and Language Therapist, Lancashire Teaching Hospitals NHS Foundation Trust

Staffing

Level	Number
Band 7 (neuro trained)	0.6 WTE
Band 6 (interest in stroke)	1.0 WTE
Band 4	1.0 WTE

Band 7 OT also has managerial responsibilities.
Band 4 Assistant Practitioner provides rehabilitation to general medical patients on Ward 6.
OTs provide input into stroke patients and general medical patients on ward 6 (ASU).

The OTs are based on the Acute Stroke Unit (ASU). The ASU admits patients with all severity of stroke, many will be ready for discharge within a few days; others will need several weeks or months of rehabilitation. The low numbers of therapists mean that the focus of work is on discharge planning rather than on-going rehabilitation. Rotation of these staff to other areas after a six month period can affect the quality of service given to the stroke patient. However, they link well with carers and do joint sessions with the carers.

There is limited access to functional assessment areas. At present, staff have to take patients to assessment areas in another part of the hospital which takes too long to do regularly. There is no quiet room for cognitive assessments.

OTs use several standardised assessment tools such as the HAD for depression and anxiety and MMSE for cognitive assessments.

OTs perform home visits with patients and provide a major input into discharge planning. Some of the functional assessments are performed on the home visit.

There is no OT input into the day hospital. There is no Early Supported Discharge Team to expedite discharge or provide rehabilitation at home. The Ward OTs are able to follow up selected patients for two weeks. The lack of OT following discharge means that it is not clear how planning for return to work, return to driving and return to leisure activities are organised.

OTs receive referrals for specialist splinting but are unable to offer this service or any follow up service as it has been withdrawn as part of Cost Improvement Programme (CIP) monies.

Examples of good practice

- Initial assessments completed early
- Two week follow up of patients

Recommendations

- Benchmark staffing levels against the national recommendations
- Find space for a quiet room
- Look at developing functional assessment areas on the ward
- Splinting service to be reinstated
- Review internal rotation requirements.

Acute Stroke Unit

Visiting Group:

Paul Davies – Consultant Stroke Physician, North Cumbria University Hospitals NHS Trust & Network Clinical Lead
Elaine Day – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Michael Dudley – Matron, A&E Department, Lancashire Teaching Hospitals NHS Foundation Trust
Chris Larkin – Deputy Regional Manager (North West), The Stroke Association

The combined Stroke Unit had recently been established on Ward 6. The unit takes acute stroke patients for the duration of their inpatient stay, incorporating acute and rehabilitation phases. This means that all levels of severity of stroke are seen on the one ward. Ward 6 is a 36 bed medical ward that the stroke physicians share with another non-stroke physician. The beds are used flexibly between stroke and general medicine with stroke patients being prioritised. The number of stroke patients is usually around 14 but did peak at 23 during December. There is a plan to provide physiological monitoring for four beds. The cubicles on the ward are frequently used for cases with transmissible infections which limits the availability of cubicles for end of life care of stroke patients. There are no specific rehabilitation facilities for stroke patients within the ward area, which means that physiotherapy is performed at the bedside or in the corridor. Patients are taken to the gym on the ground floor for rehab purposes, however this is not suitable for every patient, patients do not like the impersonal surroundings, staff find it difficult to transfer the patients there are not enough porters and using rehab time for transportation. Occupational Therapists do not have an assessment suite to assess activities of daily living. There is no quiet room for cognitive function testing or speech and language therapy. The team were well aware of these issues and were working towards internal solutions.

Most patients are admitted from the MAU within 24 hours of admission to hospital. There are a few direct admissions and the ambition is to increase this. Patients are usually on a stroke pathway by the time they are transferred to Ward 6.

The staff are very well motivated and are keen to take the developments further. They have developed multi-disciplinary notes, developed a whiteboard system to monitor progress against the Sentinel Audit Key Indicators and a stroke notice board. There is good access to junior medical staff during working hours and out-of-hours. There are regular MDT meetings with representatives of all disciplines, which are also attended by the Stroke Association Family and Carer Support Workers.

The whole team were aware of the Thrombolysis developments and were supportive of the process.

We were made aware of a shortage of nursing staff possibly as much as 8 WTE, which needs to be looked at further. The RCN recommendation is that a minimum establishment of **12.5 WTE nurses for every ten stroke beds.**

We were also made aware of the difficulties discharging patients, with patients having to wait for packages, placement in care homes etc.

Examples of good practice

- Whiteboard for key indicators ensures patients care are continuously monitored
- Joint notes
- MDT leaflets – carers can link with MD Team
- Stroke notice board

Recommendations

- Ring-fence beds for stroke patients to allow direct admissions
- Provide some cubicles for stroke patients to allow privacy during end-of-life care
- Provide suitable therapy space for therapists and patients to work without distractions and with privacy
- Benchmark staffing skills and numbers against national averages and recruit to adequate staffing levels

Speech and Language Therapy

Visiting group:

Jeannie Hayhurst – CVD Commissioning Lead, NHS Blackpool
Jan Huddleston – Speech & Language Therapist, Lancashire Teaching Hospitals NHS Foundation Trust

Staffing

Level	Number
Band 8b Manager	0.6 WTE clinical
Band 6	2.0 WTE
Band 5	2.0 WTE

The Speech and Language Therapy Department provide input into both Royal Lancaster Infirmary and Furness General Hospital. They provide 14 sessions of therapy to all departments on the FGH site per week. The team also provide outpatient Speech and Language Therapy through the Day Hospital. Different members of the team are based at FGH on different days which at times may lead to problems with continuity. There is no dedicated SLT support worker to continue work programmes “prescribed” by the therapists. A support worker may help in providing the continuity from the therapists. A member of the SLT team attends the MDT on the stroke unit each week.

Referrals to the SLT team are made verbally from ward staff.

All bar one of the team is dysphagia trained. They are providing dysphagia training to the nurses on ASU. They are also negotiating video-fluoroscopy sessions for advanced swallowing assessments. The team are looking into the way the swallowing assessment is recorded to assist with the audits. There are good links with the catering department, where staff are standardising the modified textured meals.

Nasogastric (tube) feeding is frequently used on the ward but some concerns were raised about whether the decision to commence tube feeding was made early enough. This is a difficult area, with decisions made on an individual basis and no strong recommendations for practice should be made. However, it is an area that could be audited against the standards in the RCP guidelines.

Time for communication therapy would appear to be limited. Joint working with the OTs is limited because of the lack of staff in both teams. The lack of a quiet room, free from distractions, for therapy on the ward was again highlighted.

The team are well motivated and feel like they are very involved in the developments of the stroke service at FGH, further dysphagia training has been purchased and extra training sessions are being delivered.

Examples of good practice

- Good involvement with MDT
- Providing dysphagia training to ward staff (extra training purchased ? ongoing)
- Manager of service also works clinically, therefore also has a working knowledge of service

Recommendations

- Benchmark staffing against national averages
- Develop a quiet room
- Audit of tube feeding protocol
- Continue dysphagia training for Ward 6 and MAU.

Dietetics

Visiting group:

Beverly Drake – Assistant Service Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Natalie Park – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

Staffing

Level	Number
Band 7	1.6 WTE
Band 7 renal	0.6 WTE
Band 5	2.0 WTE

Patients are referred verbally to the dietetic staff and most are seen the same day. The staff do not regularly attend the MDT but feedback via the SLT.

Baseline nutrition assessment is with the MUST tool and 12 nurses are now trained in its use. Weighing patients is not yet routine on ASU, although as 90-10 target weight has been highlighted as an issue. Bed scales are in the process of being purchased so that all patients are routinely weighed on admission (requisition for scales have been signed off, however paperwork has not been processed through procurement yet, they were ordered in October 2009 (six month wait Why?). The team suggested that food diaries are not always completed accurately on the ASU.

There is currently no nutrition link nurse on the ASU.

An emergency feeding regimen is in place for patients when they commence tube feeding.

Examples of good practice

- Respond to referrals quickly
- Well developed protocols for tube feeding.

Recommendations

- Develop a nutrition link nurse to help with education of staff on the ward about nutrition, MUST assessments, food diaries and weighing patients
- Purchase scales (also necessary for Thrombolysis drug calculations in the A&E Dept who, alongside Royal Lancaster site, are also waiting for their scales (on same requisition form, four sets of scales have been ordered).

Physiotherapy

Visiting group:

Tracy Walker – Community Stroke Rehabilitation Team Leader, NHS Blackburn with Darwen
Karen Waywell – Occupational Therapist, Blackpool, Fylde & Wyre Hospitals NHS Foundation Trust

Staffing

Level	Number
Band 7	p/t WTE no stoke input
Band 6 based at Croslands day hospital	1.0 WTE
Band 6 based on acute stroke unit	1.0 WTE
Assistants	2.0 WTE

The Band 6 Physiotherapists are both interested in stroke and both are doing MSc qualification in stroke. Rotation of these staff to other areas after a six month period can affect the quality of service given to the stroke patient. The caseload for the therapist based on ASU would seem high, particularly when the assistants leave to cover other wards after 10.30 in the morning. Despite the low level of staff the therapists are seeing patients nearly every working day, but they do not always see patients within the Sentinel Audit criterion of 48 hours. The Physiotherapists also cover MAU.

As previously mentioned, there is a lack of therapy space on the current ward. Patients have to be taken from the ward for therapy. This is often wastes time in transporting patients and some patients will not be well enough to leave the ward. In addition, nurses and nursing assistants miss the opportunity to be involved in some of the therapy.

The therapists have recently taken delivery of some equipment for rehabilitation, however they said there was a shortage of wheelchairs.

The therapists use the joint stroke pathway notes. There is no routine use of outcome scores such as Rankin scores or Barthel and Nottingham ADL scores yet. MDT goal setting has not been formalised yet.

A journal club has been established.

After discharge from the acute unit most patients receive outpatient physiotherapy at Croslands Day Hospital. Transfer of care documents need to be developed.

Examples of good practice

- Specialist Neuro physiotherapists
- Journal club.

Recommendations

- Review number of therapists and assistants
- Try and establish space for rehabilitation
- Review internal rotation requirements.

Summary

The Network visit occurred at a time when the stroke service at FGH had gone through considerable change. It was clear from all the staff that we met that they felt involved in the change, were proud of the changes made, and had the ambition to improve the service. The team that have instigated these changes to service have clearly worked hard and should be applauded.

The initial impressions in A&E were very positive and the stroke champion there has spent time educating the A&E team on FAST tests and ROSIER tests and has developed a stroke information board.

The links with imaging are good, but concerns about how Lorenzo might interfere with good face to face communication were raised. The imaging targets for CT head scans and Carotid Ultrasound appear to be met most of the time. There seems to be little capacity to increase the use of MR imaging for TIA at present and a business case should be looked at to develop this in line with National Stroke Strategy.

As is the case in other hospitals, MAU adds little to the stroke patients' management. Ideally, direct admission to the Acute Stroke Unit should be developed.

The Acute Stroke Unit is a new development and would not be counted as a "combined unit" in the National Sentinel Audit. It has recently become a combined unit and limited alteration to the environment to make it fit for purpose has yet to be completed. The prioritisation of the cubicles for patients with infections seems to disadvantage patients with stroke who may require cubicles for end of life care. Some of the processes of working together as an MDT are still coming together, but the joint notes, pathway and whiteboard all seem to be working well. It is difficult to be clear about the level of nursing and therapy staffing which would appear to be quite low. We have included the national averages from the 2009 Sentinel Audit based on 10 stroke beds. We are not clear how many additional commitments your "stroke" staff have outside the care of stroke patients. We do not underestimate the amount of work that has been undertaken and realise how long it takes for new systems to gel. The ward champion who is trying to keep everybody involved with the pathway and ward notes is clearly keeping the team motivated; she is also the team leader for the 90/10 initiative which commenced in January 2010.

The level of therapy following discharge from hospital is very low. There is no Specialist Early Supported Discharge Team. Most patients get out-patient physiotherapy delivered by a Specialist Physiotherapist at the Day Hospital, the Occupational Therapists can follow up for two weeks after discharge, but no service available in the Day Hospital, for which a business case is now being developed. Speech and Language Therapists follow up at the Day Hospital.

The Neurovascular Clinic provides a very good service. It is available as a one-stop clinic five days per week with imaging the same day.

Everyone was aware of the future development of a Thrombolysis service for stroke patients. Most were looking forward to it and thought it was a good to have this treatment available at FGH. From experience we know that there is a lot of training to do before starting and the Network will be willing to help wherever they can.

Recommendations

- Continue training all staff in stroke recognition and thrombolysis for acute stroke
- Plan for staffing requirements for Telestroke (out of hours thrombolysis)
- Ensure that Lorenzo works for stroke patients rather than stroke patients having to fit to the requirements of Lorenzo
- To explore whether additional portering time would lead to more efficiency
- To develop MRI scanning for TIA and stroke in line with the National Stroke Strategy
- Stroke patients should be admitted directly to ASU
- Ring-fence beds for stroke patients to allow direct admissions
- Ensure adequate numbers of nurses to undergo dysphagia training
- Carry out workforce review of nursing and therapists, including numbers and skills, benchmarked against national averages, internal rotation and study leave
- Provide some cubicles for stroke patients to allow privacy during end-of-life care
- Provide suitable therapy space for therapists and patients to work without distractions and with privacy, including development of a quiet room
- Carry out an audit of tube feeding protocol
- Develop a nutrition link nurse to help with education of staff on the ward about nutrition, MUST assessments, food diaries and weighing patients
- Develop Specialist Early Supported Discharge Team for stroke patients in line with National Stroke Strategy and RCP Guidelines
- Review Community Rehab and development of transfer of care documentation
- Review OT splinting service
- Investigate input of voluntary services within the Community Day Hospital.
- Need to establish neuro OT input into stroke rehabilitation following discharge

Appendix 1

University Hospitals of Morecambe Bay NHS Trust – Furness General Hospital Site Map

Appendix 2

Peer Support Visiting Group

Consultant Stroke Physician	Dr Paul Davies	Cumberland Infirmary
Service Development & Improvement Manager	Elaine Day	Cardiac and Stroke Networks
Assistant Service Improvement Manager	Beverly Drake	Cardiac and Stroke Networks in Lancashire & Cumbria
A&E Manager	Michael Dudley	Royal Preston Hospital
CVD Commissioning Lead	Jean Hayhurst	NHS Blackpool
Speech and Language Therapist	Jan Huddleston	Royal Preston Hospital
Deputy Regional Manager (North West)	Chris Larkin	Stroke Association
Service Development & Improvement Manager	Natalie Park	Cardiac and Stroke Networks in Lancashire & Cumbria
Project Co-ordinator	Kay Smith	Cardiac and Stroke Networks in Lancashire & Cumbria
Community Stroke Rehab Team Leader/Clinical OT	Tracy Walker	NHS Blackburn with Darwen
Occupational Therapist	Karen Waywell	Blackpool Victoria Hospital

Appendix 3

Peer Support Hosting Departments

MORNING **9.45 am**
Croslands Day Hospital – Rehabilitation
Christine Butler - Unit Manager
Rose Kelly - Maple Unit Manager (Risedale)
A&E Department
Christopher Wilson - Charge Nurse
Julie Weatherburn – Sister
MAU
Tanya Holmes - Ward Manager
Imaging
Christopher Whiteside - X-Ray Head of Department
Linda Womack - Imaging Services Manager
OT Department
Annabel Youngson - Occupational Therapy Stroke Lead
AFTERNOON **1.45 pm for 2.00 pm**
Acute Stroke Unit
Mark Lippett – Ward Manager
Kim Barker - Staff Nurse/Lead for Stroke
Steve Newby - Occupational Therapist
Rebecca Unsworth - Ward Sister
Speech & Language Department
Emily Foster - Speech and Language Therapist
Physiotherapy
Sarah Mallinson - Physiotherapist
Dietetics Department
Katy Gillespie - Dietician