

Southport & Ormskirk Hospitals NHS Trust

Southport & Formby District General Hospital & Ormskirk District General Hospital Peer Support Visit 30 September 2010

Feedback Report

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Summary

A team from the Cardiac and Stroke Networks in Lancashire & Cumbria (CSNLC) visited Southport & Ormskirk Hospitals NHS Trust (SOHT) on 30 September 2010. Although SOHT sits properly within the footprint of the Cheshire and Merseyside Cardiac and Stroke Network local clinicians have expressed a wish to participate in the Telestroke project run by the CSNLC. This Peer Support Visit was the eighth in a series planned by and for CSNLC. The purpose of these visits is not related specifically to the Telestroke project but is to review service provision at all sites within the Network so that clinicians, managers and commissioners may benefit from an external view and to allow exchange of good practice between various departments and Trusts within the Network.

The visiting team included a Consultant Physician/Clinical Lead for the Stroke Network, Nurses, Therapists, Service Improvement Managers and Network Directors representing five organisations within the CSNLC. There was also representation from the Cheshire & Merseyside Cardiac & Stroke Network. The day comprised meetings with service managers and clinicians from SOHT and local Social Services, and 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.

It was apparent to the visitors that there is a genuine enthusiasm within the locality to provide a high class service for patients who have suffered stroke. The Trust has begun stroke thrombolysis and Drs McDonald and Horsley are active participants in the CSNLC Clinical Advisory Group. Great efforts have already been made by the local clinicians and managers using local and national drivers (Cardiac and Stroke Networks, Sentinel Audit, National Stroke Strategy, 90:10 initiative, etc) to improve the service.

This report is presented in a sectional format which aims to mirror the stroke patient's journey from the hyperacute phase in A&E, through the acute phase on CCU & ASU, rehabilitation ward at Ormskirk District General Hospital, and back to the community via Neuro-Rehabilitation Team Sefton and ABI Team West Lancs. At the end of each section we have tried to identify areas of good practice and to offer suggestions for areas which we feel might be improved.

It is our hope that the visitors will have been viewed as critical friends rather than inspectors and that their findings will aid local teams to enhance the care offered to service users.

We hope that the report will be helpful to the team in SOHT in further developing their services.

The team would like to thank the staff at SOHT for their warm welcome and the assistance offered to us during the day.

Background



SOHT comprises Southport & Formby District General Hospital (SDGH) and Ormskirk District General Hospital (ODGH) and serves a population of approximately 229,000. Neighbouring trusts are Lancashire Teaching Hospitals NHS Foundation Trust at Preston to the north and Aintree University Hospital to the south. Medical services are commissioned by Sefton PCT for Southport residents and Central Lancashire PCT for the populations of Ormskirk & Skelmersdale. The elderly are over represented in the Southport population while Skelmersdale contains areas of social deprivation.

The Hospital expects to admit 500 stroke cases per year from the population served and the majority of these will come via the Emergency Department. Acute stroke admissions come via the 8 acute beds then to the 15 rehab beds SDGH (Combined unit) or to the 16 rehabilitation beds on Ward A, ODGH. Thrombolysis patients are treated initially on the Coronary Care Unit under the care of the Stroke team and are transferred to the Stroke unit after 24 hours.

The Trust offers a weekday TIA outpatient service.

The service is led by Drs Horsley and McDonald with support from therapy staff, and a Stroke Specialist Nurse who works across both sites. There is close collaboration with the Accident and Emergency service and the Department of Radiology.

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 of Physicians Guidelines for the management of stroke. The audit is in two parts; organisation and process. Organisational measures include the number of stroke beds, whether there is direct admission to a stroke unit, the provision of thrombolysis, and the composition of the stroke team.

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

National Sentinel Audit Results - for Trusts within the Network

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 Infirmary)	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	✓	✓
Southport and Ormskirk Hospital	5-24 hours	5-24 hours	25-48 hours	>48 hours	Yes	Yes	7	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 Middle Half Interquartile Range Lower Quartile

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		
Southport and Ormskirk Hospital	(60)	82	61	96	100	5	94	100	93	46	4		

Key: Upper Quartile  Middle Half Interquartile Range  Lower Quartile 

Above National %	↑
Below National %	↓

Dr McDonald presented local data regarding outcomes which compare very favourably with national figures (Appendix 2).

Overview of SOHT Stroke Pathway

Patients are usually admitted as emergency cases either by self referral, referral from General Practitioner or via a 999 call to North West Ambulance Service (NWAS).

Patients being considered for thrombolysis are transferred rapidly from the Emergency Department (ED) to the CT scanner and thence to CCU. If the patient is unsuitable for thrombolysis he will be admitted directly from ED to the stroke unit (Ward 9A).

At the time of the visit the stroke thrombolysis service was available in the Trust between 0900-1700h Monday to Friday and opportunistically at other times.

After the acute phase of care patients are transferred to Ward A at Ormskirk District General Hospital for rehabilitation.

Emergency Department (ED)

Visiting group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead

Jennifer Watts – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria

Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

Christina Lawrenson – Emergency Dept Manager, Lancashire Teaching Hospitals NHS Foundation Trust

Lisa Downham – CCU Manager, University Hospitals of Morecambe Bay NHS Trust

The pathway for stroke patients is well defined. The department has an arrangement to receive pre-alert from North West Ambulance Service (NWAS). If patients self present they may wait at reception but receptionists have recently had some training with regards to use of the FAST (Face, Arm, Speech, Time) tool. ROSIER (Recognition of Stroke in the Emergency Room) is carried out in ED.

Between 0900-1700h stroke patients are triaged by nursing staff and referred directly to the stroke team. During working hours patients will have a CT scan within one hour in the adjacent Radiology Department. Request cards for CT are carried to the department and the patient is sent for when the scanner is available. After CT the patient returns to the ED: in those suitable for thrombolysis treatment is commenced and the patient is then transferred to the CCU for 24h. After this, and immediately for those not eligible for thrombolysis, patients are admitted directly to the Acute Stroke Unit (ASU), Ward 9A. There appears to be no problem with bed availability in CCU however sometimes there may be a wait for a bed on ASU. The staff in ED are happy to keep people in the department while awaiting the ASU bed.

Thrombolysis is available only between 0900-1700h Monday to Friday but staff are keen to roll this out to 24/7. It is envisaged that this will happen with the implementation of the Network Telestroke programme.

Between 1700-0900h and at week ends ED staff refers patients to the on call general medical staff and they are admitted directly to ASU.

The Stroke Nurse Specialist works 0900 – 1500h but is not based within ED.

There is a strong consultant presence in ED and the five consultants are trained in the use of the National Institute of Health Stroke Score (NIHSS). Consultants are present until 2200h on weekdays and from 0900-1500h at week-ends. Presently stroke thrombolysis is performed by the stroke physicians but the ED consultants are keen to participate.

Currently, with in the ED, they do not do swallow assessments.

The ED staff in the feel that they require more continuous training (25% trained in basics of thrombolysis).

The ED department are aware of three new Stroke Nurse Clinicians but are unsure of their role within ED but would like more stroke specific staff to work alongside ED Team.

TIA Services

TIA patients are referred daily into the rapid access clinic. Referral into the system is via fax (usually from GP or ED). Most patients seen on the next working day. Dedicated clinics are held on Monday (Ormskirk) and Friday (Southport). On Tuesday, Wednesday & Thursday – 2 extra slots are provided in routine clinics for urgent TIAs. This has enabled quicker access for high risk patients.

At weekends the ED department still admit patients with high risk TIA to ward.

The ED has written protocols in place for the prescription of Aspirin, Statins and investigations for appropriate patients.

Areas of Good Practice

1. The acute stroke service works well between 0900h-1700h
2. There is a strong consultant presence in the ED
3. The ED receives good support from the stroke team
4. ED staff are aware of stroke pathways within the Trust
5. Good liaison between ED and radiology departments
6. Team are keen to improve Stroke specific knowledge and skills

Suggestions for further work

1. Establish STAT (Stroke and TIA Awareness Training) as soon as possible
2. Further training in FAST for receptionists
3. Rolling training programme to take account of staff turnover and new starters
4. Develop a leaner system for CT referrals e.g. telephone call or electronic referral form
5. Awareness campaign and training in preparation for Telestroke programme
6. Consider having Stroke Clinician Nurses in the department
7. Implementation of guidelines for high risk TIA patients who present at the weekend. This will prevent the need for some admissions
8. Provide stroke/TIA specific information leaflets in department.

Imaging

Visiting Group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead

Jennifer Watts – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria

Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

Christina Lawrenson – Emergency Dept Manager, Lancashire Teaching Hospitals NHS Foundation Trust

Lisa Downham – CCU Manager, University Hospitals of Morecambe Bay NHS Trust

The Hospital has one 4 slice CT scanner and one MRI scanner. At the time of our visit a new 64 slice CT scanner was being installed but had not been commissioned. The new scanner will have capability for perfusion scanning. Between 0900 – 1700h ED staff take request cards to the Department for CT. Stroke patients are scanned as urgencies but the availability of the scanner may be limited because of other cases. During working hours patients for thrombolysis are scanned immediately if the scanner is available. From 1700h the CT scanner is closed except for emergencies but there is a local agreement to scan all potential thrombolysis patients up to 2200h. This is based upon an analysis of the times of presentation to the hospital of thrombolysable patients. At present any stroke patient presenting after 1700h will be scanned as soon after 0900h as possible the following day. The remainder are scanned within 24 hours of admission. Images are immediately available via PACS and are hot reported by one of the 7 consultant radiologists in the department which enables the report to be on the system within 30 mins.

Out of hours radiographer staffing - Southport site:

Three Radiographers until 2030h: after this there are two Radiographers available until 0830h the next day. One of these is CT trained but from 0030h may need to travel to cover scans at Ormskirk thus leaving the Southport site without CT cover temporarily. The staff are aware of the proposal for 24h Telestroke service for thrombolysis but are concerned about the implications of cross site cover for this.

TIA

The department provides radiology input for the five day TIA service and offers CT angiography within 48h of request. Reports on these are available by 1700h on the day of scanning. There is no routine MRI scanning of TIA patients.

The staff were aware of Network developments in the field of Telemedicine, to provide a 24/7 Thromobolysis service, but feel that this will have implications for cross-site cover and think that further work is needed on looking at time of patients presenting out of hours,

Areas of Good Practice

1. Rapid and timely access to CT scanning for stroke patients
2. Good working relationships with other departments
3. Good patient flow and documentation
4. Good support for TIA services

Suggestions for further work

1. Develop a leaner system for CT referrals e.g. telephone call or electronic referral form
2. Capacity and demand exercise for MRI scanning for TIA.

Coronary Care Unit (CCU)

Visiting group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead

Jennifer Watts – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria

Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

Christina Lawrenson – Emergency Dept Manager, Lancashire Teaching Hospitals NHS Foundation Trust

Lisa Downham – CCU Manager, University Hospitals of Morecambe Bay NHS Trust

The staff on CCU felt that they had been closely involved in the development of the stroke thrombolysis pathway.

Patients who receive thrombolysis are transferred from the ED to CCU for monitoring and regular observations over the first 24 hours of their admission. After this time the patients are transferred directly to the acute stroke unit (ASU).

Staff on CCU are informed of a patient for thrombolysis after the CT scan has been done. This allows them time to create a bed if necessary. Patients are transferred to CCU by ED staff. The Stroke Physician reviews the patient on CCU and carries out the NIHSS at two hours. There are pathways and protocols in place to assist staff in case of deterioration of the patient post thrombolysis.

CCU staff do not carry out swallowing or NIHSS assessments but felt that there was adequate support from the stroke physician or speech and language therapist if either of these was required. There is good access to OT and physiotherapy if required.

There is rotation of basic grade nursing staff through critical care, CCU and high dependency unit (HDU) but senior nurses felt that this was positive and assisted with learning and maintaining staff competencies. The rotation does not appear to deplete stroke care competencies amongst the basic grade staff. There was apprehension initially but feel positive dealing with thrombolysed patients.

Areas of Good Practice

1. Staff competent and confident in management of thrombolysis for stroke patients
2. Pathway and protocols in place for management of routine and complicated patients
3. Bed always made available for stroke thrombolysis.

Suggestions for further work

1. Nursing staff have some concerns about medical cover when Telestroke goes live. It may be worth doing some further training around this
2. Demand and capacity exercise to scope feasibility of a ring fenced bed for stroke
3. Move thrombolysis from CCU to ASU (this is the view of Dr Damien Jenkinson, National Clinical Lead for Stroke).

Emergency Assessment Unit (EAU)

Visiting group:

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

Yvonne Potts – Stroke Ward Manager, East Lancashire Hospitals NHS Trust

Jan Vaughan – Network Director, Cheshire & Merseyside Cardiac & Stroke Network

This 27 bed unit is no longer part of stroke pathway: The staff have worked in partnership with the bed managers and ED staff to ensure that patients go directly to ASU. There are however occasions when patients with stroke from Sefton PCT referred to hospital from the Call Centre are admitted to the EAU. This appears to be because of poor clinical information resulting in misplacement of the patient. Patients from Central Lancashire PCT are admitted to ASU via Bed Managers.

If the EAU staff diagnose a patient with acute stroke and the ASU is full the bed managers will move non-stroke patients from ASU other medical wards to create a bed.

Areas of Good Practice

1. EAU is no longer part of the stroke pathway resulting in a leaner patient journey
2. Work with bed managers to facilitate admission of stroke patients to EAU.

Suggestions for further work

1. Work with Sefton PCT to prevent inappropriate admission of stroke patients to EAU.

Vascular Services

Visiting Group:

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

Yvonne Potts – Stroke Ward Manager, East Lancashire Hospitals NHS Trust

Jan Vaughan – Network Director, Cheshire & Merseyside Cardiac & Stroke Network

The service has one full time Vascular Scientist and one 0.4 WTE Radiographer. There is no formal arrangement for leave cover but Radiology accepts urgent cases. There is a close working relationship with the Radiology Department.

The service operates 0900-1700h Monday – Friday. If high risk TIA patients present at a weekend they are allocated first slot on Monday.

The service offers a One Stop Clinic on Friday with Dr McDonald at Southport. Patients from Dr Horsley's clinic in Ormskirk are not scanned immediately and will be offered the next available slot.

There is a good working relationship with Mr Jones (Vascular Surgeon) and high risk patients are prioritised for endarterectomy in 2 - 3 weeks.

Areas of Good Practice

1. One stop clinic at Southport

Suggestions for further work

1. Formalise leave cover arrangements
2. Offer one stop clinic at Ormskirk
3. Capacity demand exercise to ensure all appropriate endarterectomies performed within two week time window.

Acute Stroke Unit (Ward 9A)

Visiting Group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead

Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

Christina Lawrenson – Emergency Dept Manager, Lancashire Teaching Hospitals NHS Foundation Trust

Lisa Downham – CCU Manager, University Hospitals of Morecambe Bay NHS Trust

Yvonne Potts – Stroke Ward Manager, East Lancashire Hospitals NHS Trust

The Stroke Unit (Ward 9a) is situated on the second floor and has space for 30 beds: 20 are designated for stroke, 3 for medicine and 2 further beds are unfunded. There are, in addition, a further 5 beds which may be used for escalation which means that sometimes up to 30 patients are accommodated on the ward. Admissions come from ED, EAU or by transfer from another medical ward.

Nurse staffing levels are as below:

3 trained/2 - 3 untrained in morning

2 trained/2 untrained in afternoons

2 trained/1 untrained for night shift

The ward uses a stroke pathway and accepts patients from CCU post thrombolysis. A Patient Group Directive (PGD) is in place for Aspirin which enables the ward to give aspirin in a timely fashion.

There are protocols for emergency feeding and continence management. Nasogastric tubes are bridled when appropriate to reduce the risk of repeated removal. There is good access to PEG placement with most requests being filled within seven days. There is a falls risk assessment tool which aids in the low number of reported falls.

The ward has 3 mobile telemetry systems with a central station based on the nurse's station. The ward is well equipped with 3 hoists, one of those being a weighing hoist.

The patients on the ward are able to attend family meetings as requested and MDT meetings are held weekly with ward rounds during the week. The unit works with two social services – Sefton & Central Lancashire. There is no stroke specific social worker but the Sefton Social Worker attends MDTs. There do not appear to be significant delays in discharges.

The Stroke Association has two workers covering the unit and they attend the MDTs.

They would like more storage on the ward as equipment is often in the way. The ward staff would also like to see the removal of the unfunded beds as this would create storage space within the ward environment.

Areas of Good Practice

1. Use of Stroke pathway
2. Majority of staff are Dysphagia assessment trained
3. Protocol for emergency feeding
4. Protocol for continence management
5. Use of Falls Risk Assessment Tool
6. Use of Physiological monitoring equipment
7. Regular MDTs
8. Social Service attendance at MDT
9. Stroke Association involvement

Suggestions for further work

1. Establish Early Supported Discharge Team
2. Establishing thrombolysis on ASU
3. Staff training programme to include STAT, ROSIER, and thrombolysis specific refreshers
4. Create ring fenced bed for stroke admissions.

Family Support

Visiting group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead

Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria

Christina Lawrenson – Emergency Dept Manager, Lancashire Teaching Hospitals NHS Foundation Trust

Lisa Downham – CCU Manager, University Hospitals of Morecambe Bay NHS Trust

Yvonne Potts – Stroke Ward Manager, East Lancashire Hospitals NHS Trust

At present there are two Family and Carer Support Workers from the Stroke Association who are contracted for 35 hours each: 30 hours on the ward and covering 5 hours communication support until someone has been employed into the role of Communication Support Worker. There is a new communication support person to start in October in the community.

The workers pick up all stroke patients who are admitted to ASU. Currently they only come to ward once per week to attend MDT and to collect referrals. If a referral is missed they can pick up the patient from the monthly Stroke Register. Whilst patients are on the ward they give them a pack with core information leaflets about stroke and these are then tailored to make them patient specific.

There is one patient/carer group per month with at least 15 stroke survivors attending each event. Different venues are chosen to help keep up membership and cover the area. They work with the Stroke Club which is affiliated to the Stroke Association.

The workers are able to put carers in touch with each other to facilitate self help and they can refer to psychology if they feel that this is appropriate

All patients are followed up for up to 12 months and some for longer if it felt necessary.

Areas of Good Practice

1. Communication support
2. Very enthusiastic.

Suggestions for further work

1. Another member of staff
2. Continued funding in the future.

Speech and Language Therapy

Visiting group:

Carol Ann McElhone – Associate Programme Director - Cardiac and Stroke Networks in Lancashire & Cumbria
Coamha Preston – Physiotherapy Team Leader, NHS Blackburn with Darwen

The service operates Monday – Friday and is provided by 1 WTE Band 7, 1 WTE Band 5 (split between Stroke and General Medicine) and a Band 5 currently studying on an accredited (post graduate) dysphagia course.

Referrals are accepted from the nursing staff, Occupational Therapists and Physiotherapists. They also receive handover every morning from nursing staff on ASU.

If patients fail dysphagia screening undertaken by ward nurses they are referred to SLTs and usually are seen the same day.

The therapists feel that they have good joint working with other specialties within the acute stroke unit. They attend the weekly MDT meetings and are now involved with screening for Mood. They have a stroke team schedule (joint sessions with other therapies) which works well and are piloting joint documentation and joint goal setting.

Good links have been built with the community teams with whom they meet for journal clubs. This has strengthened working relationships and assisted in a smoother patient pathway.

The staff have developed booklets for MDT to aid conversation with severely dysphasic patients. They offer In-service training within MDT for supported conversation.

Patient information leaflets are provided as required.

Areas of Good Practice

1. Patient information leaflets
2. Handover every morning with nursing staff
3. Good joint working with other specialties
4. Good links have been built with the community teams
5. Piloting joint documentation and joint goal setting
6. Therapist studying on dysphagia course.

Suggestions for further work

1. More space to work in (availability of quiet space)
2. Laptop and therapeutic software for communication.

Physiotherapy

Visiting group:

Michelle Walne – Senior Staff Nurse, East Lancashire Hospitals NHS Trust

Alastair Houghton – Programme Manager for Stroke, Cheshire & Merseyside Cardiac & Stroke Network

The physiotherapists cover neurology and stroke services. There are 2.5 WTE Band 7, 1 WTE Band 6 (rotational) and 1 WTE Band 5 (rotational). The service is provided Monday to Friday with a limited Saturday service. Management has looked at 7 day service but at present the cost seem to out weigh the benefits. The physiotherapists feel that they work well together and have a good skill mix within their team.

There is face to face handover and patients are seen daily and within 24 hours of admission. There is adequate staffing to provide 45 minutes therapy daily unless there is a sudden absence from sickness etc.

There are close working relationships with medical, nursing and therapy staff. Because of lack of space on the unit the team uses a timetable for patients to assist staff with timings for therapy.

Referrals to the Community Team are sent two weeks prior to discharge to try to minimise delay. Early Supported Discharge is a concern as community services are not stroke specific and it is felt that intensity and specificity of the service could be improved.

Areas of Good Practice

1. Good working relationships
2. Enthusiastic and flexible team
3. Initial assessment of patient is usually done on day of admission.

Suggestions for further work

1. Equipment – need more wheelchairs and additional standing hoist
2. Storage on unit is an issue
3. Further therapy space.

Occupational Therapy

Visiting group:

Kay Smith - Service Development & Improvement Manager - Cardiac and Stroke Networks in Lancashire & Cumbria

Karen Waywell – Occupational Therapist – Blackpool Fylde & Wyre Hospitals NHS Foundation Trust

The staffing is 3 WTE Band 6, 1 WTE Band 6 (rotational), 1 WTE Band 5 (rotational). There is also generic therapy support (2 WTE Band 2, 1 WTE Band 3) who also help with administration. The static Band 6 has had specific training in stroke.

The OT team will take verbal referrals: they are happy to take referrals from wards other than ASU but mainly see patients on ASU. They attend the weekly MDT and as required hold family meeting.

Their base is near ASU (Ward 9a) although there is limited therapy space available on the ward. Because of this they work with the other therapists to use a timetable to maximise time and space available. Good relationships have been built with nursing staff and inter disciplinary team working with SLTs and Physios is working well. They are currently looking at new pathways for Mood screening and apraxia

They consistently meet 100% target for OT assessment of stroke patients within 4 days of referral. Patients are usually seen by 48 hours if they are appropriate.

They have good internal training but limited external training opportunities. They offer induction, supervision and training to the team at Ormskirk.

Areas of Good Practice

1. Attendance at MDT
2. Attendance at Family meetings
3. Active rehabilitation goal setting
4. Good working relationships with all other MDT members
5. Meeting 100% targets
6. Time table to maximise therapy space utilisation.

Suggestions for further work

1. Establish an Early Supported Discharge Team in line with recently published Accelerating Stroke measures
2. Look at possibilities of an allocated space on the ward for OT currently limitations – physical resources
3. More quiet space to carry out some assessments.

Dietetics

Visiting group:

Kay Smith - Service Development & Improvement Manager - Cardiac and Stroke Networks in Lancashire & Cumbria

Natalie Park - Service Development & Improvement Manager - Cardiac & Stroke Networks in Lancashire & Cumbria

There are 3.8 WTE dietitians (4 staff) for adults across Southport and Ormskirk. There is 1 WTE Band 7, 0.8 WTE Band 6 and 2 WTE Band 5. The Band 6 works solely on Oncology, the remainder of the service is generic, not stroke specific and only approximately 10% of time is dedicated to stroke.

Because of staff numbers there is an impact upon the team's ability to respond in a timely manner to referrals and attend MDT meetings.

Referrals are taken by phone and card.

The dietitians have good working relationships with all MDT members including ward staff and have an emergency feeding regime in place which is utilised as required. The MUST (Malnutrition Universal Screening Tool) is not used on the ASU: the dietitians however use another tool for malnutrition screening. Patients are screened on admission and weekly thereafter.

The ASU does not have a nutritional link nurse group and there is no training on the acute stroke unit provided by dietitians to nurses on ward although there is good access to training internally and externally and a rolling programme of education which staff can utilise. Feeds are presently ordered by pharmacy rather than the dietitians.

Areas of Good Practice

1. Use of Nutritional tool (not MUST)
2. Use of emergency feeding protocol thus preventing delays in feeding.

Suggestions for further work

1. Full time stroke specific dietitian to be more proactive and permit attendance at MDT
2. Increase awareness of role of dietitian
3. Issue re enteral feeds – ordered by pharmacy not dieticians.

Rehabilitation Unit (Ward A) - Ormskirk

Visiting group:

Kathy Blacker - Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria
Michelle Walne – Senior Staff Nurse, East Lancashire Hospitals NHS Trust

This is a 22 bedded generic rehabilitation unit which can accommodate 66% stroke patients. Staffing levels are 26 WTE:
2 trained, 3 HCAs for early shift
2 trained, 2 HCAs for late shift
2 trained, 1 HCA for night shift

Currently no nurse has stroke training, and there is no training programme in place. It would be difficult to release staff for training at present.

The ward is large and although there is a day room patients do not use it. There is also some work required in the bathrooms to make these accessible to stroke survivors. More wheelchairs are needed to assist in patients getting about the ward and going out and about.

Stroke survivors can be transferred as early as day 4 in the stroke pathway, although there is usually a waiting list for their beds. The ward has a turnover time of approximately 15 days

Full functional assessments are carried out prior to discharge. Weekly MDTs are well attended. The ward provides stroke specific information to stroke survivors but currently there is no Stroke Association presence and no local stroke group.

There is a good team spirit amongst staff but OT input is limited and is more focused around discharge. There is no out of hours physiotherapy service which may result in patients having to be taken back to Southport for treatment.

There is a delay between patients leaving hospital and starting with community therapy team.

Areas of Good Practice

1. Multidisciplinary team working
2. Weekly MDT meetings
3. Full functional assessments prior to discharge
4. Discharge planning process.

Suggestions for further work

1. Need for more equipment e.g. wheelchairs
2. Bathroom needs adapting and modifying for use of disabled patients
3. Implementation of Stroke training programme for staff
4. More OT input to permit treatment rather than just discharge planning
5. Work to remove delay between hospital and community therapy teams treatments.

Community Rehabilitation ABI Team – West Lancs

Visiting group:

Anita Tunstall - Community Stroke Matron – NHS Blackpool

Richard Penswick - Practice Development Nurse, Cardiac & Stroke Network in Lancashire & Cumbria

This service is provided by NHS Central Lancashire.

The Neuro Team comprises 23.01 WTE staff and covers stroke & ABI (acquired brain injury) patients. A prerequisite for acceptance by the team is that the patient requires input from at least two therapies. For patients who require only one therapy they will be referred to one of:

- Domiciliary physiotherapy (not stroke specific)
- Stand alone SLT
- Intermediate care – OT or Physiotherapy
- Dietetics

The Neurorehabilitation team waiting time is 10 days maximum and it takes referrals from the Acute Trusts and GPs.

Clinical information received on referrals can be poor (but improving).

Team members would like to attend MDTs but do not currently due to of lack of capacity.

There is not always a good flow of documentation from the Acute Trust and the team would like more effective use of the Transfer of Care document.

No psychology input at Ormskirk.

Community Neuro- Rehabilitation Team – Sefton

Visiting group:

Carol Ann McElhone - Associate Programme Director - Cardiac and Stroke Networks in Lancashire & Cumbria

Coamha Preston – Physiotherapy Team Leader, NHS Blackburn with Darwen

Jan Vaughan – Network Director, Cheshire & Merseyside Cardiac & Stroke Network

The team is based at Southport Centre for Health and Wellbeing.

Staffing levels are:

1 WTE Band 7 0.5 WTE Band 7/6 Physiotherapists

1.5 WTE Band 7 OT,

1.5 WTE Band 7 SLT (funded) – only 0.7 WTE during term time, 0.6 WTE Band 4 Trainee Assistant Practitioner, 0.4 WTE Band 4 SLT Assistant

There is no nursing or psychologist input.

There is approximately a 50/50 split between stroke patients and other neuro conditions. Referrals come from anyone in primary or secondary care, social services or by self-referral. Referrals are received by fax or phone. The Acute Trust tries to provide notice prior to patients discharge (two weeks if possible). The team then contacts the acute therapists with follow up appointment date for patient. There are no set referral criteria and the team accepts acute and 'old' strokes. There is a perception that the stroke patients who are now referred are more dependent than previously. This may be because of a decreased length of hospital stay.

The team try to see patients within two weeks of discharge. Each discipline can see a patient up to twice a week and will continue to see patients for as long as there is improvement. Patients are able to self-refer back into service if needed.

There are monthly formal MDTs and informal daily MDTs to discuss cases. Joint documentation and goal setting is in place and appears to be working well along with the use of Therapy Outcome Measure (all disciplines). They use the most relevant Outcome Measure for patients. There is no dedicated social worker (but do joint visits as required). No ESD component.

The Neuro Team appear to have good links with Stroke Association.

Psychology

Visiting group:

Anita Tunstall - Community Stroke Matron – NHS Blackpool

Richard Penswick - Practice Development Nurse, Cardiac & Stroke Network in Lancashire & Cumbria

There is clinical psychology input one day per week for stroke in North Sefton, split half acute/rehabilitation and half community. The psychologist predominantly uses a solution focused approach and a Mood Assessment Tool (which although is non validated the team feel it is more meaningful for patients and useful for staff). This was developed from feedback from service users and therapists.

The clinical psychologist attends therapy team meetings and feels this is positive and the psychologist is viewed as part of the team.

The psychologist aims to facilitate both direct and systemic work, involving family members for aphasic patients.

They are looking at using alternative methods involving family members for aphasic patients.

The service also offers input to families/carers and there are multiple methods of referral. This is a flexible service and not strictly time limited, to be most useful to patients and families coping with the potentially long-term nature of living with stroke.

The psychologist is currently undertaking staff training and all staff are very receptive and want to develop service further, maximising the use of minimal clinical psychology resources.

Recommendations

Emergency Department

1. Establish STAT (Stroke and TIA Awareness Training) as soon as possible
2. Further training in FAST for receptionists
3. Rolling training programme to take account of staff turnover and new starters
4. Develop a leaner system for CT referrals e.g. telephone call or electronic referral form
5. Awareness campaign and training in preparation for telestroke programme
6. Consider having Stroke Clinician Nurses in the department
7. Implementation of guidelines for high risk TIA patients who present at the weekend. This will prevent the need for some admissions
8. Provide stroke/TIA specific information leaflets in department.

Imaging

1. Develop a leaner system for CT referrals e.g. telephone call or electronic referral form
2. Capacity and demand exercise for MRI scanning for TIA.

Acute Phase

1. CCU nursing staff have some concerns about medical cover when Telestroke goes live. It may be worth doing some further training around this
2. Demand and capacity exercise to scope feasibility of a ring fenced bed for stroke
3. Move thrombolysis from CCU to ASU. (It is a requirement in the Sentinel Audit and within the National Stroke Strategy that stroke patients should be treated in stroke units. We have sought the opinion of Dr Damien Jenkinson, National Clinical Lead for Stroke whose view is that treatment on CCU does not satisfy these standards. The view of the Network is that you have taken a pragmatic approach to the provision of thrombolysis for stroke patients which is clinically safe and works within your existing stroke pathway.)
4. Work with Sefton PCT to prevent inappropriate admission of stroke patients to EAU. This may require some joint training with their staff
5. Establish Early Supported Discharge Team. This is a requirement within the advancing stroke improvement framework
6. Staff training programme to include STAT, ROSIER, and thrombolysis specific refreshers
7. Create ring fenced bed for stroke admissions on ASU (see 3. above).

TIA Services

1. Formalise leave cover arrangements for Vascular Services
2. Offer one stop clinic at Ormskirk
3. Capacity demand exercise to ensure all appropriate endarterectomies performed within two week time window
4. Capacity and demand exercise for MRI scanning for TIA
5. Review referral pathway to service in light of time taken to see urgent cases (Appendix 3).

Rehabilitation Therapy Services

1. Need for more equipment e.g. wheelchairs
2. Bathroom (Ormskirk) needs adapting and modifying for use of disabled patients
3. Implementation of Stroke training programme for staff (Ormskirk)
4. More OT input to permit treatment rather than just discharge planning
5. Work to remove delay between hospital and community therapy teams treatments
6. Full time stroke specific dietitian to be more proactive and permit attendance at MDT
7. Consider changing system for ordering of enteral feeds from pharmacy to dietitians
8. Establish an Early Supported Discharge Team in line with recently published Accelerating Stroke measures
9. Look at possibilities of an allocated space on ASU for OT currently limitations – physical resources
10. More quiet space to carry out some assessments. More space to work in (availability of quiet space)
11. Laptop and therapeutic software for communication (SLT).

Community Services

1. There is a difference between the services offered by NHS Sefton and NHS Central Lancashire. This should be removed as far as possible
2. Referral to the services should be streamlined with better clinical information
3. Work needs to be done to remove any delay in therapy provision when patients are discharged to the community services
4. So far as is practicable stroke specific rather than generic services should be established in line with national guidance.

Appendix 1

Peer Support Visiting Group

Consultant Physician/ Clinical Lead	Dr Mark O'Donnell	Blackpool, Fylde & Wyre Hospitals NHS Foundation Trust/Cardiac & Stroke Networks in Lancashire & Cumbria
Joint Director of Cardiac and Stroke Network	Kathy Blacker Jennifer Watts Jan Vaughan	Cardiac & Stroke Networks in Lancashire & Cumbria Cheshire & Merseyside Cardiac & Stroke Network
Service Development & Improvement Managers	Carol Ann McElhone Natalie Park Kay Smith Sharon Doyle	Cardiac & Stroke Networks in Lancashire & Cumbria
Practice Development Nurse	Richard Penswick	Cardiac & Stroke Networks in Lancashire & Cumbria
Programme Manager for Stroke	Alastair Houghton	Cheshire & Merseyside Cardiac & Stroke Network
Community Matron	Anita Tunstall	NHS Blackpool
Emergency Dept Matron	Christina Lawrenson	Lancashire Teaching Hospitals NHS Foundation Trust
Stroke Ward Manager	Yvonne Potts	East Lancashire Hospitals NHS Trust
Senior staff Nurse	Michelle Walne	East Lancashire Hospitals NHS Trust
CCU Manager	Lisa Downham	University Hospitals of Morecambe Bay NHS Trust
Physiotherapist Team Leader	Coamha Preston	NHS Blackburn with Darwen

Appendix 2

Stroke Outcomes

	2008 Southport	2008 RCP audit	2010 local
Age	77.9 years	75.2 years	74 years
Sex	43% Male	47% Male	54% Male
Home	44%	66%	61.1%
Long term care	24%	11%	14.3%
Death	32%	23%	21.4% (74% vigil)
Overall LoS	21.5 days	23.7 days	15.7 days

2010 n = 126, Sefton = 61.1% Central Lancs = 34.4%

Stroke Outcome

Month	Age	PCT	LoS	Home	LTC	Death	Delay	Delay time	
May n=31	74.9	45.1 S 45.1CL	16.45 days	51.6%	22.5%	19.4%	29%	13.8 days	
June n = 30	74.6	70 S 30 CL	15.8 days	50%	20%	30%	13.3%	12.5 days	
July N=33	75.6	63.3 S 33.3CL	13.4 days	66.7%	6.1%	24.2%	18.2%	9.0 days	

May Stroke severity 1 12.9% 2 35.5% 3 6.5% 4 16.1% 5 12.9% 6 16.8%
 June Stroke severity 1 32.1% 2 7.1% 3 21.4% 4 14.3% 5 15.2% 6 25%
 July Stroke severity 1 21.2% 2 15.2% 3 18.2% 4 12.1% 5 15.2% 6 18.2%

Stroke Severity

Severity	No %	Age	Female	LoS	Death	Home	LTC	Rankin
1	24 (19)	80.6	50%	13.6	87.5%	8.3%	4.2%	6
2	23 (18.3)	76.9	47.8%	35.6	26.1%	24.7%	43.5%	5
3	16 (12.7)	76.5	56.3%	20.4	0	56.3%	37.5%	3
4	18 (14.3)	69.7	27.8%	15.5	0	100%	0	2
5	15 (11.9)	76.6	53.3%	5.6	0	100%	0	2
6	30 (23.8)	66.4	43.3%	2.8	0	93.3%	3.3	2

Appendix 3

Vital Signs TIA and 90% stroke stay

