Cardiac & Stroke Networks LANCASHIRE & CUMBRIA

NHS

Cardiac and Stroke Networks in Lancashire & Cumbria

North Cumbria University Hospitals NHS Trust

West Cumberland Hospital

Peer Support Visit
11 October 2010

Feedback Report

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Appendix 1

Summary

The Peer Support Visit to the Stroke services at West Cumberland Hospital (part of North Cumbria University Hospitals NHS Trust) was the ninth and last in a series planned by and for the Lancashire and Cumbria Stroke Network. The purpose of these visits is to review service provision at all sites within the Network so that clinicians, managers and commissioners may benefit from an external view.

It was apparent to the visitors that there is a genuine enthusiasm within the locality to provide a quality service for patients who have suffered stroke. The Trust has been one of the earliest adopters of stroke thrombolysis in the local stroke network and has been selected as the host provider for the Network's Telestroke service. Great efforts are already being 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 further improve the service.

The 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 and through Ullswater acute stroke rehabilitation ward. 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. At the end of the document is a summary of our recommendations.

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.

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

Background

West Cumberland Hospital along with Cumberland Infirmary comprise North Cumbria University Hospitals NHS Trust. West Cumberland Hospital with four community hospitals in Cockermouth, Marypool, Millom, and Workington serve a population of 130,00. The medical services are commissioned by Cumbria PCT.

The Hospital expects to admit 200 – 230 stroke/TIA cases per year from the population served and the majority of these will come via the Emergency Department.

The stroke unit was established in 2004, a daily neurovascular clinic in 2006 and thrombolysis for stroke began in 2009. Between 2001 and 2010 the median length of stay for stroke patients has halved to 9 days and the mean length of stay has fallen from 55 to 22 days resulting in 8000 bed days saved per annum. The stroke service is regularly in the top quartile of the country as reported in the National Sentinel Audit for stroke. A very commendable 10% of stroke patients are recruited to research studies.

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Introduction

A team from the Cardiac and Stroke Networks in Lancashire & Cumbria visited West Cumberland Hospital on 11 October 2010. The purpose of the visit was to allow exchange of good practice between various departments and Trusts within the Network. The team visiting West Cumberland Hospital included a Consultant Physician/Clinical Lead for the Stroke Network, A&E Matron, Occupational Therapist, Ward Managers and nurses, Service Improvement Managers and Network Directors representing five organisations within the Stroke Network. There was also representation from the Cheshire & Merseyside Cardiac & Stroke Network who wish to collaborate with us in the Telestroke project.

The day comprised meetings with service managers and clinicians from West Cumberland 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.

Everyone involved in the visit valued the warm welcome that was extended to the visiting group by the staff at West Cumberland and was impressed with the individuals who provide the care in all the departments visited. Questionnaires from each department visited were completed prior to the visit and the following report is based on the information from these, the meetings and feedback that the team received during the day.

We hope that the report will be helpful to the team in West Cumberland 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 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

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 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	✓	✓

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**

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 West Cumberland Hospitals Stroke Pathway

Patients are usually admitted as medical emergencies. This may be by self referral, from General Practitioner referral or via a 999 call to North West Ambulance Service (NWAS).

The ideal pathway is for patients to be transferred rapidly from the Emergency Department (ED) to the CT scanner and thence to Coronary Care Unit/Acute Stroke Unit (CCU/ASU) after thrombolysis or direct to CCU/ASU if the patient is not suitable for thrombolysis.

The stroke thrombolysis service is 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 Ullswater – Acute Stroke Rehabilitation Ward.

Emergency Department (ED)

Visiting group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead
Kathy Blacker – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Trish Whalley – Emergency Department Manager, University Hospitals of Morecambe Bay NHS Trust
Dr Matt Tedford – Southport & Ormskirk Hospitals NHS Trust.

The ED department has approximately 29,000 attendances a year and was readily meeting the previous 4h target for treatment. There are three Consultants and an associate specialist in the department. Currently there is no Clinical Nurse Specialist for stroke within the Trust. There has been some training for reception staff around FAST (Face, Arm, Speech, Time) test and this is used in conjunction with the ROSIER (Recognition of Stroke in the Emergency Room) too.

The pathway for potential stroke patients is well defined and the process through the unit in and out of hours is robust. The department receives a pre-alert from NWAS for potential stroke patients. After triage by the nursing staff patients are assessed by medical staff and between 0900-1700h are scanned rapidly. Patients eligible for thrombolysis are returned to ED where a decision regarding treatment is made in consultation with the stroke physician. Thrombolysis is given in ED. All consultants in ED are trained in the use of the NIHSS (National Institute for Health Stroke Scale). After completion of thrombolysis patients are transferred to CCU/ASU. Thrombolysis is currently available between the hours of 9 - 5 but staff are keen to roll this out to 24/7.

There is a good service to the ED from the Radiology Department. During working hours patients will have a CT scan within one hour. Out of hours there may be a delay of 30 min (while waiting for the on-call radiographer). There was a view expressed by some staff that this delay may become an issue with the introduction of the 24/7 Telestroke service. At present request cards are physically transported to the radiology department.

There does not appear to be a problem with accommodating all new stroke admissions on ASU/CCU although there may be a slight delay while patients are moved from the unit to create a bed.

TIAs mostly come from GP through to Nurse Practitioners but those presenting to A&E are diverted to Nurse Practitioner service but may be admitted at weekend.

Stroke Association Contribution
The ED recommends the provision of Stroke/TIA advice support information in the Department, unfortunately these went unrecognised. There were five FAST posters on display across waiting areas, triage areas and link corridors. A broad selection of stroke prevention and stroke information leaflets were on display as per planning and discussion with the ED Sister.

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. ED consultants trained in NIHSS
4. The ED receives good support from the stroke team
5. ED staff are aware of stroke pathways within the Trust
6. Good liaison between ED and radiology departments.

Suggestions for further work

1. Establish STAT (Stroke and TIA Awareness Training) as soon as possible
2. Awareness campaign and training in preparation for Telestroke programme
3. Implement leaner system for CT requests.
4. Implementation of guidelines for high risk TIA patients who present at the weekend. This will prevent the need for some admissions

Imaging Department

Visiting Group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead
Kathy Blacker – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Trish Whalley – Emergency Department Manager, University Hospitals of Morecambe Bay NHS Trust
Dr Matt Tedford – Southport & Ormskirk Hospitals NHS Trust.

The Radiology department provides an excellent service between the hours of 9 - 5, providing good access to CT for stroke and TIA.

The department has one 16 slice CT scanner capable of diffusion imaging although this software is not currently used. There is a mobile MRI scanner on site two days a week and for a third day once a month: this is used primarily for work other than stroke imaging. There is a new build in progress which will have space for a static MRI scanner but there is some doubt as to whether this will come to fruition.

The majority of new stroke patients presenting within hours are CT scanned within one hour of referral using the next available slot. This necessitates squeezing these cases into existing imaging lists. Delays may arise as there is only one scanner and it may be in use for a prolonged procedure such as biopsy, etc. The remainder of patients (i.e. those presenting out of hours) are scanned within 24 hours of admission. Out of hours there may be up to one hour delay for CT scan while the on call radiographer travels to the hospital. There is no plan currently to train all radiographers to do CT heads. During the hours of 9 - 5 ED staff take request cards to the Radiology Department for CT. This process is facilitated by the close proximity of Radiology to the ED and the good working relationships which exist between the two departments.

Carotid Doppler imaging is performed in the department by a Consultant Radiologist one day per week and a Radiographer 0.5 days per week. A full time Radiographer is due to return soon from leave. There is no clear pathway for the imaging of high risk TIA patients.

The department is currently running below establishment because of staff retirement and a recruitment freeze. This situation is likely to worsen in the near future because of further retirements and the possibility of staff taking maternity leave.

Areas of Good Practice

1. Staff accommodate stroke patients as soon as practicable
2. Work with ED for urgent scanning of thrombolysis patients.

Suggestions for further work

1. Review urgently the work force planning for this department
2. Consider training all radiographers to scan for stroke in preparation for Telestroke project
3. Capacity and demand exercise for MRI imaging for TIA (this is recommended modality in National Stroke Strategy)
4. Work with Stroke Physician and ED staff to agree pathway for urgent imaging of high risk TIA patients
5. Work with ED staff on leaner request process for urgent scans.

CCU/ASU

Visiting group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead
Kathy Blacker – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Trish Whalley – Emergency Department Manager, University Hospitals of Morecambe Bay NHS Trust
Dr Matt Tedford – Southport & Ormskirk Hospitals NHS Trust.

The ASU/CCU has 8 beds which are used flexibly for coronary or stroke patients. Staffing levels 1:4 (2 qualified & 1 HCA). This is inadequate for the number and dependency of patients.

Patients who have been thrombolysed are transferred from the ED to ASU/CCU for continuous physiological monitoring and regular observations over the first 24 hours. They are reviewed there by the stroke physician who performs the two hour NIHSS assessment. There are pathways and protocols in place to guide staff in the case of a patient's deterioration. Acute patients stay on ASU/CCU for 24-72 hours and after are then transferred out. There may be a delay in the admission of acute patients while an existing patient is discharged to Ullswater (stroke rehabilitation unit), Honister, or Jenkin ward to create a bed.

Some stroke patients are admitted directly from GP via Bed Manager: these are seen by the doctor on call for the unit. ASU/CCU does not admit end of life patients and they are admitted to EAU (Ennerdale Unit). Patients who suffer in hospital stroke are transferred to CCU/ASU.

There are six dysphagia trained nurses who can carry out swallow screening. If patients are unable to swallow there is an emergency regime for tube feeding which is initiated on the instruction of the consultant. The ward does not have MDT meetings but does have visits by therapists from the Stroke Unit.

The ASU/CCU is actively engaged in several research studies and the 90:10 project.

Patient care suffers from the ward having no weighing hoist, no specialist seating for stroke survivors and no designated therapy space. The staff expressed some concern about facilities in the new build.

Areas of Good Practice

1. Acute patients nursed in specialist area
2. All thrombolysed patients accommodated
3. High number of nurses trained in dysphagia assessment
4. Protocols in place for management of dysphagic patients and those who deteriorate post thrombolysis.

Suggestions for further work

1. Work with Ullswater and bed management team to ensure bed availability for acute admissions and timely transfer of patients who are ready for rehabilitation
2. Work with Ullswater to ensure that all patients are discussed at MDT
3. Provision of weighing hoist and specialist seating for stroke patients
4. More information to staff regarding new build.

Emergency Assessment Unit (EAU)

Visiting group:

Kay Smith – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Graeme Nicholson – A&E Manager, University Hospitals of Morecambe Bay NHS Trust

This unit has 30 beds, 15 beds for Patterdale/15 beds for Pillar. All admissions either from ED or by GP referral are facilitated by the Bed Manager.

The unit is unlikely to admit stroke patients and has worked hard to streamline the stroke patient's journey by removing EAU from the pathway. The staff have worked with Bed Managers and ED to ensure patients go directly to ASU/CCU. The only time that stroke patients may go to EAU is if they are demented or for terminal care. The EAU often admits patients with TIAs at weekends or if it is felt that for any reason they are not fit to be sent home.

Areas of Good Practice

1. Is no longer part of the stroke pathway

Honister & Jenkin Wards

Visiting group:

Kay Smith – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Graeme Nicholson – A&E Manager, University Hospitals of Morecambe Bay NHS Trust

There are two wards with 30 beds on each: each unit is into 2 x 15.
Staffing levels are four qualified and two HCAs on two x 12 hour shifts. Honnister tends to admit patients below and Jenkin those over 75 years of age. The ward staff have struggled because of facilities but there has been a recent refurbishment of some of the bathrooms and provision of wet rooms. The side rooms are large and patient movement within them is not a problem: the 4 bedded bays however are not so spacious.

The pathway from ASU/CCU follows the patient to Honister but the staff find pathway complicated and difficult to follow and feel that they need more formal training. The wards add their own care plans to pathway.

Multi disciplinary team members are not stroke specific but they can tap into the stroke specific service if necessary. The wards only see on average 1 – 2 strokes per month and staff feel that this can impair their competencies. There is no MDT meeting on Honister: Jenkin does have MDTs but these are not stroke specific.

Patients may wait 2 – 3 weeks for transfer to Ullswater and consequently some patients may be discharged from hospital without admission to the stroke rehabilitation unit.

20 – 30% of staff on Honister and the majority of staff on Jenkin are dysphagia assessment trained. For those patients unable to swallow, doctors insert NG tubes on Honister: neither ward uses nasal bridles. Both wards have emergency feeding regimes in place but their use is decided by the consultant.

Honister has no weighing hoist, no specialist seating for stroke survivors and no designated therapy space and Jenkin would like a review of patient base (disease specific) of ward. Both wards feel they require more information for patients.

Areas of Good Practice

1. High number of nurses trained in dysphagia assessment
2. Use of stroke care pathway
3. Use of emergency feeding regimes for dysphagic patients.

Suggestions for further work

1. Staff training on use of stroke pathway
2. Work with Ullswater and bed managers to facilitate admission of all stroke patients to rehabilitation unit
3. Work with Ullswater to ensure that all patients are discussed at MDT
4. Provision of weighing hoist and specialist seating for stroke patients.

TIA Services

Visiting group:

Kay Smith – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Graeme Nicholson – A&E Manager, University Hospitals of Morecambe Bay NHS Trust

TIA services are provided by the Nurse Practitioner Unit (NPU) with consultant overview. There are six Nurse Practitioners (NP) who work 0800 – 1800h Monday to Friday. They cover the NPU and EAU. The TIA assessment unit is based on Gable ward. On average eight patients per week attend TIA clinic.

TIA patients are referred daily into the NPU by two routes: the first is that the GP will ring (while the patients are still with them) the NPs who arrange for the patient to attend the NPU or ED; the second is via fax to Dr Orugun's secretary. She prints the referral and then takes it to the NPs who will contact the patient and usually see them within 24 hours or on the next working day if referred over the week end or Bank Holiday

In the TIA clinic bloods, history, ECG, CXR and CT scan are carried out on the same day on all patients and Echo is done as required. Carotid duplex scanning is done as an outpatient: this may take up to two weeks. Transport can be an issue in getting patients to and from TIA clinic.

At weekends and out of hours some TIA patients are admitted to Patterdale Ward.

Stroke Association Contribution

On entry to Gable Ward Again the FAST posters and Stroke info/Advice booklets were on display for patient use as well as on the information boards within the wards and outside on the concourse between Gable and Honister Wards.

Areas of Good Practice

1. Good service in working hours
2. Good liaison between NP and radiology departments
3. Team are keen to improve Stroke specific knowledge and skills.

Suggestions for further work

1. Audit clerk to input TIA data
2. Structured training for NPs around TIA and Stroke
3. Implementation of guidelines for TIA patients who present at the weekend may prevent admission
4. Streamline referral pathway and consider prioritisation of high risk cases.
5. Same day Carotid Doppler to provide a true one stop clinic

Acute Stroke Rehabilitation Unit (Ullswater)

Visiting Group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead
Kathy Blacker – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Trish Whalley – Emergency Department Manager, University Hospitals of Morecambe Bay NHS Trust
Dr Matt Tedford – Southport & Ormskirk Hospitals NHS Trust.

Ullswater has 16 beds (13 stroke beds/3 YDU) with a plan to reduce to 14. The ward clerk actively seeks stroke patients by telephoning the wards in the rest of the hospital. The average LOS is approximately 30 days and there may be a delay of 2 – 3 days before patients are admitted.

The ward establishment is perceived to be adequate but currently there is a problem with long term sickness and are using bank staff (sickness and recruitment freeze). There are six nurses trained in dysphagia assessment and three more receiving training. PEG tubes are inserted without delay by Dr Russell. The ward has MDTs with patients and their carers one week after admission and again one week before discharge. There are weekly MDTs and four Consultant (Drs Orugun and Russell) ward rounds per week. The ward staff use a 90:10 dashboard which helps with weekly MDT.

Communication on the unit appears to be good: the staff use an electronic handover sheet which is updated at each shift. There is also a whiteboard to identify key workers and steps in the patient's journey. The staff ward have good relationships with the stroke association and there is a small amount of psychology input but the ward would like this to be increased.

Patients may experience delays in discharge for several reasons: while waiting for home adaptations; awaiting funding for residential care; referral to STINT: referral to community rehabilitation services. Staff can refer into the STINT Team for a six week package of care which may be extended to 12 weeks if required. There may be a 2 week wait for STINT. There appears to be no clarity re referral to community services. There is no Early Supported Discharge team. On discharge each patient receives an individualised Stroke Health Record Document.

The unit is involved in the Stroke Research Network's programme and is actively recruiting to seven studies. A high proportion of patients is enrolled in studies.

There is a lot of uncertainty amongst staff about relocation of the Stroke Unit, and anxiety about the impending staffing review.

Staff identified a problem with the provision of urinary continence pads which are limited to three per day per patient.

Areas of Good Practice

1. Majority of staff are Dysphagia assessment trained
2. Ease of access to enteral nutrition
3. Regular MDT with patient and carer involvement
4. Regular consultant ward rounds
5. Good communication between staff
6. Individualised Stroke Health Record Document on discharge
7. Stroke Association involvement.

Suggestions for further work

1. Establish Early Supported Discharge Team
2. Review discharge process with appropriate agencies to reduce delay and length of stay
3. Further communication with staff regarding relocation

Stroke Association

Visiting group:

Mark O'Donnell – Consultant Stroke Physician, Blackpool Fylde & Wyre Hospitals NHS Foundation Trust & Network Clinical Lead
Kathy Blacker – Network Director, Cardiac and Stroke Networks in Lancashire & Cumbria
Sharon Doyle – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Trish Whalley – Emergency Department Manager, University Hospitals of Morecambe Bay NHS Trust
Dr Matt Tedford – Southport & Ormskirk Hospitals NHS Trust.

At present there are two Family and Carer Support workers who are contracted for 24 hours each per week. They visit the ward 3 – 4 times a week. This service is commissioned by the local Social Services and the present funding will finish in March 2011.

The workers pick up all stroke patients who are admitted to ASU and all other areas within the hospital and they actively seek out patients. Whilst patients are on the ward they receive an Information Pack with core leaflets: extra information is added to make them patient specific before discharge. The workers aim to make face to face contact with the patient between 4 and 7 days post admission. All patients and families are followed up for up to 12 months but some longer dependant on need.

90% of patients/families and Carers are seen face to face within 2-7days following admission and in line with the post stroke pathway, i.e. from CCU to Ullswater Ward.

The Support Workers are actively involved in areas for Transfer of Care prior to patient discharge and Post Stroke Primary Care Assessment in line with National Stroke Strategy. They are also actively involved in Patient/Family Carer Discharge Planning. Planned follow up support is provided via phone/face to face contact within 4 days of discharge.

The Stroke Association has been involved in a number of projects e.g. Identified need for, designed and implemented medication card and have been involved with the local stroke group in developing My Stroke Health Care Document.

There is Stroke Link – computer access point funded by local stroke groups.

Areas of Good Practice

1. Communication support
2. Very enthusiastic
3. Active involvement in running of ward
4. Active involvement in design and implementation of documentation.

Suggestions for further work

1. Encourage Social Services to continue funding this service after March 2011.

Speech and Language Therapy

Visiting group:

Heather Duff – Rehab Coordinator –Southport & Ormskirk Hospitals NHS Trust
Graeme Nicholson – A&E Manager, University Hospitals of Morecambe Bay NHS Trust

Staffing levels - 0.8 WTE Band 7 for Stroke and 1.0 WTE Band 3 Speech Assistant who both work with inpatients and in the community. The Band 7 assesses patients and draws up a programme for Band 3 to complete in community. There is a Band 8b SLT to cover all other wards and who will do swallow assessments on outlying strokes.

Referrals are accepted from the nursing staff, Occupational Therapists and Physiotherapists and the dysphagia assessment trained nurses on Ullswater. The service sees all stroke patients and each has a communication screen by the Speech Assistant. The team is achieving national swallow targets. The therapists attend the weekly MDT meetings

There is a good dysphagia nurse training package in place with a register of how many swallow assessments nursing staff are doing. This facilitates identification of the requirement for refresher training.

Patients discharged from the STINT team after 6 or 12 weeks are referred to community SLT Team. Therapy input reduces at this time to once per week or less. To supplement lack of community services there is a 'Speech after Stroke' Club. A weekly club which is locality based and run by an organiser (0.8 WTE term time only). These clubs currently have 40 volunteers and focus on supported conversation. In addition there are monthly lunch groups – allocated to patient need (meet in pub), and have activity outings once per month which utilises voluntary transport system. There is a plan for more impairment focused groups run by SLTs following STINT.

Four voluntary workers visit the ward to provide support. There are also 'Communication Partners' who have been funded by the Stroke Network to attend Connect training. It is hoped to roll out this programme further.

The department has received funding from the Snowball Fund for one laptop which is used on the ward. It is hoped to purchase a further three laptops and software that can be lent to patients in community.

Areas of Good Practice

1. Good joint working with other specialties
2. Good links have been built with the community teams
3. Good training package for nursing staff.

Suggestions for further work

1. Purchase further laptops and software to enhance therapy
2. Further discussion with staff regarding service changes.

Physiotherapy

Visiting group:

Kay Smith – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Alastair Houghton – Programme Manager for Stroke, Cheshire & Merseyside Cardiac & Stroke Network

This team which covers the Acute Rehabilitation Stroke Unit provides support to other areas within the hospital – Honnister and Jenkin.

Staffing levels are three WTE therapists and one WTE assistant. The physiotherapists feel that they work well together and have a good skill mix within their team. They have a face to face handover of patients and they are seen within 24 hours of admission Monday to Friday. All acute patients receive 45 minutes of care during the acute phase.

Physios regularly attend the MDT meetings. Because of a lack of long term follow-up patients may be kept longer than would otherwise be the case. The therapists feel that they have a close working relationship with medical and nursing staff and that they have good facilities with excellent communal areas which it is felt enhances psycho social aspects of rehabilitation.

Currently there is a good in-house training programme.

Referral systems are in place to Community STINT teams but there can be delays before these are accepted. If the delay exceeds 28 days the case is cancelled and has to be re-referred.

Areas of Good Practice

1. Good working relationships
2. Enthusiastic and flexible team

Copeland STINT

Visiting group:

Kay Smith – Service Development & Improvement Manager, Cardiac and Stroke Networks in Lancashire & Cumbria
Alastair Houghton – Programme Manager for Stroke, Cheshire & Merseyside Cardiac & Stroke Network

The Copeland STINT Team covers Egremont, Distington and as far south as Millom. The team comprises 2.69 WTE physiotherapists, 1.97 WTE Occupational therapists, 3.19 WTE Rehab assistants (generic), 2 WTE Assistant practitioners, 0.24 speech and language therapists, 2 Social workers and 1 nurse.

There are very good working relationships with Ullswater Rehabilitation Unit and the team is able to see patients on the unit if necessary. This aids discharge planning and good transfer of care from the unit. The STINT team used to attend MDT meetings but because of pressure of work no longer have the capacity to do this.

The team currently has 50 patients on its caseload and of these 10% are stroke survivors. The service is time limited to 6 weeks (patients can self refer back into service) but there can be delays getting patients into service which has a knock on effect that causes backlog on Ullswater unit. Complex patients who self re-refer, and any who require treatment from two staff members, may cause further delayed discharges because of limited capacity in the team.

All staff have had some stroke training and some team members have worked on the stroke rehabilitation unit.

Copeland STINT would like more flexibility by Copeland Unit (extending 14 day stay) to increase capacity. They have not considered ESD model due to low numbers but may be willing to relook at this in the future. Patients are allocated on a needs basis but this may be limited by availability of capacity and appropriately skilled staff.

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Areas of Good Practice

1. Review patients on Stroke Rehabilitation Unit if necessary

Suggestions for further work

1. Look to establishing a stroke specific team
2. Refine admission criteria to service
3. Use goal attainment scoring to guide length of treatment
4. Review community rehabilitation including ESD team

Occupational Therapy

Visiting group:

Natalie Park - Service Development & Improvement Manager - Cardiac and Stroke Networks in Lancashire & Cumbria
Alastair Houghton – Programme Manager Stroke, Cheshire & Merseyside Cardiac & Stroke Network

The Occupational Therapists offer a five day service and are employed by the local PCT. Staffing levels are as follows:

- 1 Band 7 - 22 hours
- 1 Locum full time Band 6
- 1 rotational Band 5 (nine months)
- 1 Band 4 (Day Hospital)
- 1 Band 4 – Stroke Unit
- 1 Band 6 not replaced on Day Unit – Stroke OT Team provide cover for this post

All of the above are stroke specific. There is no cover for sickness/annual leave.

The therapists cover 16 beds on ASU (13 stroke/3 YDU beds) and four on ASU/CCU plus outlying strokes. In addition they make community visits up to twice per week: this usually entails a half day away from the hospital and is done without cover on site. They attend the weekly MDT meetings and any ad hoc family meeting as required.

The department is near to ASRU (Ullswater) and this helps with good team working with other therapists. Currently the have access to good kitchen and workspace. The therapists achieved only 14% in March for their 72 hour treatment target (thought to be because the Band 7 was on leave). The latest figure is 57%

Provision of special seating for discharge can cause delays because of the split of funding for this between social services and health budgets. If patients are discharged to nursing home there is no clarity as to who funds the seating.

They have good internal training and link in with other MDT members to provide in-house training.

Areas of Good Practice

1. Attendance at MDT
2. Attendance at Family meetings
3. Good working relationships with all other MDT members
4. Progress with targets.

Suggestions for further work

1. Clarification of funding streams for equipment
2. Provision of cover for leave

Dietetics

Visiting group:

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

Staffing levels –
Since March 2010 one WTE Band 7 for acute and community for West Cumbria
Have recently recruited two WTE Band 5 and one WTE Band 6 and a part time dietetic assistant. They are employed by PCT and spend three-quarters of time community based. Now that the team is more substantial they hope to raise profile within the Trust and attend MDTs as required.

Referrals are by phone and are collected on a regular basis.

They aim to provide more training and to try to develop the use of the MUST tool in both community and acute settings as currently two different tools are used which can cause confusion.

The ASU has a nutritional link nurse group. Each ward has a nutritional folder with the emergency feeding regime in. There are good pathways and protocols in place and there is no issues re access to NG feeds or PEG feeding.

Areas of Good Practice

1. Use of emergency feeding protocol thus preventing delays in feeding
2. Nutritional Link nurses in each area.

Suggestions for further work

1. Increase awareness of role of dietician
2. Training around MUST tool.

Community Rehabilitation Hospitals

Visiting group:

Richard Penswick - Practice Development Nurse, Cardiac & Stroke Network in Lancashire & Cumbria
Heather Duff – Rehab Coordinator –Southport & Ormskirk Hospitals NHS Trust

Workington

There are 14 beds on the ward.
Ward staffing: four in am (two qualified/two unqualified), three in back shift (one qualified/ two unqualified), two night shift (one qualified/one unqualified). The unit has just recruited three WTE Band 3 Rehabilitation Assistant posts (four people)

Feel staffing numbers are low and the quality of care suffers.

Therapist staffing:
Occupational therapy – one WTE Band 6 OT, two WTE Band 5 (one rotational), one WTE Band 3 Assistant (almost full time)
Physiotherapy – one WTE Band 7, two WTE Band 6 and one part time Band 3. There is little access to SLTs and dietetics (sessional).

Physiotherapists are available if specialist input is required and they will work with acute trust. The Occupational Therapists felt that they had inadequate capacity for joint working. The therapy team has had two part time neuro specific therapists but therapy service covers inpatients on ward, the Rehabilitation Centre and sees patients in their own or nursing homes.

The Rehabilitation Centre operates on one day assessment and four days treatment. Transport issues in the transfer of patients to and from the Centre limit its efficiency. Patients spend a long time travelling and not a lot of time being treated.

The unit has no set criteria for accepting patients. There is a referral form but no pathway and referrals are taken from patients themselves, GPs and the acute Trust. There is no time limit in place for length of stay.

The unit does have MDT meetings but no stroke specific staff or training. There is a Social Worker (not stroke specific) whose remit is to deal with short term needs but is often involved in long term cases. The Social Worker attends daily and gets referrals prior to discharge. For patients with long term needs Adult Social Care has an allocation meeting once a week.

Complex management structure and transitional management changes have made staff unsettled and teams are unaware of what happening in other teams.

Recommendations

1. There was general unease regarding the future in every department and service that we visited. This seems to stem from a lack of knowledge regarding plans for service redesign and accommodation in the new build. It will be helpful to address this information gap.
2. The Stroke Network will launch its Telestroke programme in the early part of 2011. Information and training around this initiative will be helpful to its smooth implementation.
3. Establish STAT (Stroke and TIA Awareness Training) as soon as possible in ED.
4. Implement a leaner system for CT requests in ED.
5. Implementation of guidelines for high risk TIA patients who present at the weekend. This will prevent the need for some admissions in ED.
6. Provide stroke/TIA specific information leaflets in ED.
7. Review urgently the work force planning in the Radiology Department.
8. Consider training all Radiographers to scan for stroke in preparation for Telestroke project
9. Capacity and demand exercise for MRI imaging for TIA.
10. Work with Stroke Physician and ED staff to agree pathway for urgent imaging of high risk TIA patients.
11. Review bed management process to ensure bed availability on ASU/CCU for acute admissions and timely transfer of patients who are ready for rehabilitation.
12. Capacity and demand exercise for bed numbers to prevent admission to inappropriate ward areas.
13. Ensure that all stroke inpatients are discussed at MDT.
14. Provision of weighing hoist and specialist seating for stroke patients in several areas.
15. Staff training on use of stroke pathway (Honister).
16. Audit clerk to input TIA data. This will help with Vital Signs monitoring.
17. Structured training for NPs around TIA and Stroke.
18. Streamline referral pathway and consider prioritisation of high risk TIA cases.
19. Provide same day Carotid Doppler scanning for TIA patients.
20. Make business case with the Stroke Association for the continuation of the Family and Carer Support workers after March 2011 (SA).
21. Purchase further laptops and software to enhance therapy (SLT).
22. Clarification of funding streams for equipment (OT).
23. Provision of cover for leave of OTs.
24. The discharge and after hospital rehabilitation is disjointed. Some rehabilitation services have rather loose referral criteria and do not seem to have very clear outcome measures. Both of these issues should be addressed.
25. Review community rehabilitation.
26. Establish Early Supported Discharge Team.
27. Review discharge process with appropriate agencies to reduce delay and length of stay.
28. Refine admission criteria to STINT service.
29. Use goal attainment scoring to guide length of treatment.

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
Stroke Registrar	Dr Matt Tedford	Southport & Ormskirk Hospitals NHS Trust
Joint Director of Cardiac and Stroke Network	Kathy Blacker	Cardiac & Stroke Networks in Lancashire & Cumbria
Service Development & Improvement Managers	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
Emergency Dept Matron	Graeme Nicholson	University Hospitals of Morecambe Bay NHS Trust
A & E Sister	Trisha Whalley	University Hospitals of Morecambe Bay NHS Trust
Rehab Coordinator	Heather Duff	Southport & Ormskirk Hospitals NHS Trust