NZ Organised Acute Stroke Service Specifications

Prepared by the National Stroke Network to outline *minimal* standards and strongly recommended standards for DHBs providing In-patient Stroke Services.

Organised Acute Stroke Services are provided by a coordinated specialised interdisciplinary team (IDT) and consist of early and ongoing comprehensive assessments and treatment which is guided by best practice. This is reflected in the use of stroke specific protocols. The IDT meets regularly to discuss, formulate and implement patient management and optimise rehabilitation and patient function. Ideally care is provided in a geographically discrete unit, but depending on DHB size this may not always be feasible.

Services provided:

- Stroke Thrombolysis available 24 / 7
- Stroke Clot Retrieval (SCR) (in designated stroke centres) or access to SCR
- Rapid TIA Access
- Acute Stroke Care
- Inpatient and Community Stroke Rehabilitation

Members of an in-patient stroke team:

Designated to stroke (not necessarily designated to stroke exclusively):

- Stroke physician*
- Stroke nurse*
- Physiotherapist
- Occupational Therapist
- Speech and Language Therapist
- Social worker

Clinicians that should be available but not necessarily members of the acute stroke team:

- Dietician
- Clinical Psychologist
- Pharmacist

* Each DHB should have a designated *lead* stroke physician and *lead* stroke nurse, and a lead allied health professional. For daily clinical activities several clinicians can share patient responsibilities on a rotating basis.

Education:

- Baseline qualifications with expectation of expertise in stroke management
- Ongoing education should include a minimum of eight hours of annual formal stroke education for each designated acute stroke team member
- Provision of education to other clinical staff working with stroke
- A credentialing process in place for physician's supervising/providing thrombolysis.

Meetings/collaboration:

- Minimum IDT meeting once a week to discuss ongoing management, goal setting, and discharge planning

Offering key components of stroke management utilising protocols with specified time frames:

- Pre-notification of stroke teams, rapid access to imaging, thrombolysis, stroke clot retrieval pathway, TIA, stroke care guidelines (medical, nursing, dysphagia, early mobilisation, functional assessments, education of patients and family), hospital transfers, discharge planning, transitions to inpatient rehabilitation or community and secondary prevention.

Links to Emergency Medical Services, ED, radiology, neurosurgery, vascular surgery, rehabilitation, Stroke Foundation.

Quality Assurance and audit

- Mandatory entry of stroke thrombolysis and clot retrieval cases to the Reperfusion Register., Regular audit processes must be in place which may be managed through the extended stroke registry. All serious adverse events should be fully investigated and discussed as a team and as appropriate used as learning opportunities at regional/national network meetings.
- Patient reported experience and outcomes are measured and monitored.

Research/Advocacy

- There should be some evidence that the service engages in clinical stroke research or stroke audits and patient advocacy relating to stroke.

Acute Stroke Unit/Organised In-patient Stroke Services

A stroke unit is defined as a discrete ward, or beds within a ward, with a dedicated specialised multi-disciplinary team (MDT) and could include acute stroke units that discharge patients to a rehabilitation service, or an integrated acute and rehabilitation unit. A stroke patient needs to be admitted/transferred to a stroke unit as soon as possible after presentation.

Hospitals designated as providing an 'Organised Stroke Service' should have a designated geographical area with stroke patients spending the majority of their acute hospital stay in this 'unit.' Ideally beds are dedicated to stroke patients. In small hospitals where a dedicated 'unit' may not be feasible due to low patient volumes patients may be admitted to a single general medical ward if all other components of an organised stroke service are provided. In this situation the patient should be seen by a member of the stroke team within 24 hours of admission. Alternatively, if organised acute stroke services are not available patients should be transferred to a larger centre using a defined pathway.

Staffing Levels

Exact FTE allocation for interdisciplinary stroke team member staffing levels has not been firmly established at this point in time. However, as a general guide staffing levels should be sufficient to enable care of patients in accordance with current Stroke Guidelines[1] approved by the National Stroke Network. All designated members of the stroke team should have some dedicated time (part- or full-time depending on patient volumes) specifically allocated to stroke care and maintenance of stroke care competencies[2].

References:

1. https://informme.org.au/Guidelines/Clinical-Guidelines-for-Stroke-Management-2017
2. https://strokenetwork.org.nz/Nurse%20Working%20Group