NZ Organised Acute Stroke Service Specifications

Prepared by the National Stroke Network to outline *minimal* standards and strongly recommended standards for DHBs.

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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
- Rapid TIA Access
- Acute Stroke Care
- Early Stroke Rehabilitation

Members of an acute stroke team:

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

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

Clinicians that add significant value to stroke care, but are not mandatory designated members of the acute stroke team:

- Dietician
- Clinical Psychologist
- Pharmacist

* Each centre should have a designated *lead* stroke physician and *lead* stroke nurse. However, for daily clinical activities several clinicians can share patient responsibilities on a rotating basis.

Education:

- Baseline qualifications yet to be defined.
- Ongoing education should include a minimum of 8 hours of annual formal stroke education for each designated acute stroke team member
- Provision of education to other staff working with stroke

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:

- Thrombolysis, TIA, stroke care guidelines (medical, nursing, dysphagia, early mobilisation, functional assessments, education of patients and family)

Links to EMS, ED, radiology, neurosurgery, vascular surgery, rehabilitation.

Quality Assurance and audit

- If providing stroke thrombolysis maintenance of a thrombolysis registry is mandatory; additional stroke registry data is desirable although regular stroke relevant audits are an acceptable alternative. All serious adverse events should be fully investigated and discussed as a team.

Research/Advocacy

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

Geographical area

Hospitals designated as providing an 'Organised Acute 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, but this is not mandatory. 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 services are provided. Alternatively, if organised acute stroke services are not available patients should be transferred to a larger centre using a defined pathway. Formalised remote support from a larger service may in some instances be a further option.

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 NZ Stroke Guidelines. All designated members of the stroke team should have some dedicated time (part- or fulltime depending on patient volumes) specifically allocated to stroke care and maintenance of stroke care competencies.

Stroke Rehabilitation beyond the acute phase

Please see NZ Organised Stroke Rehabilitation Service Specifications (in-patient and community).

NZ Organised Stroke Rehabilitation Service