WM QRS West Midlands Quality Review Service

NHS

Review of Stroke (Acute Phase) and TIA Services

Mid Staffordshire Health Economy

Visit Date: 6th December, 2011 Report Date: February 2012

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INTRODUCTION

ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

West Midlands Quality Review Service (WMQRS) has been set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on http://www.wmqi.westmidlands.nhs.uk/wmqrs/.

This report presents the findings of the review of Stroke (Acute Phase) & TIA, for the Mid Staffordshire Health Economy, which includes Mid Staffordshire NHS Foundation Trust. This visit took place on 6th December 2011. The purpose of the visit was to review compliance with WMQRS Quality Standards for:

- Services for People with Stroke (Acute Phase) and Transient Ischaemic Attack, Version 1, April 2010

This visit was organised at the request of Mid Staffordshire NHS Foundation Trust.

The purpose of these standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and patients' experiences by improving the quality of services. The report also gives external assurance of the care within the Health Economy which can be used as part of organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Appendix 1 lists the visiting ream which reviewed the services in the Mid Staffordshire Health Economy. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and patients of the Mid Staffordshire health economy, including staff from Mid Staffordshire NHS Foundation Trust, for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

Stroke (Acute Phase) and TIA Peer Review Visit

General Comments and Achievements

Considerable progress had been made with developing an acute stroke service at Mid Staffordshire NHS Foundation Trust and with the development of a service for people with TIA. Staff had put a lot of work into developing and improving the service and reviewers were clear of the potential to provide a very good acute stroke service. The team had a good understanding of the areas which still needed to be addressed. The environment on the Acute Stroke Unit was pleasant and welcoming with good use made of 'Patients at a Glance' boards.

At the time of the visit the number of patients being admitted to the Unit was small. The Trust was, however, hoping that the unit would be able to admit all patients presenting more than four hours after the onset of symptoms or who were not suitable for transfer to a hyper-acute stroke unit for thrombolysis. Reviewers considered that further work was needed in three areas before this change should be made:

- Ensuring sufficient nursing staff have achieved appropriate competences in the care of patients with stroke
- Ensuring a healthcare professional with competence in swallowing screening is available at all times
- Ensuring all Emergency Department staff have appropriate competences in the care of patients with acute stroke and are aware of guidelines and information available.

Good Practice

Reviewers identified several examples of good practice, including:

1 Therapy teams provided good support to the Unit. Patient-set goals were identified as part of the rehabilitation process and there were good links with the Early Supported Discharge service. Good use was made of skill mix.

2 Discharge planning was well organised, with discharge planning starting on the day of admission.

3 The documentation of nursing competences achieved was clear. Also, the Clinical Nurse Specialist for the stroke service had a critical care background and was helping with staff awareness of seriously ill patients and with the development of competences.

4 The Hospital Anxiety and Depression (HAD) score was used by all disciplines involved in the care of patients.

5 Good prompts reminded staff of the need to remove catheters, using the 'HOUDINI' acronym.

6 Robust systems were in place for identification of patients who had a stroke but were on other wards.

7 The Infoflex data sheet was used to collect SINAP data in 'real time' during the patient's admission. This work was supported by a data clerk who was well integrated with the clinical team.

Immediate Risks:

None

Concerns

1 Guidelines on the management of patients with stroke were not available in the Emergency Department. The website with the stroke guidelines could not be accessed from the Emergency Department and staff were not aware of their existence. The stroke pathway displayed in the Emergency Department was the pathway towards which the Trust was working and not the pathway operational at the time of the visit. Staff were not clear about the stroke and TIA pathways and it was not evident that they had appropriate competences in the recognition and management of patients with stroke (acute phase) and TIA.

2 A consultant stroke specialist was available on weekdays but not at weekends and a ward round by a senior member of the stroke team did not take place at weekends. The stroke consultant employed by Mid Staffordshire NHS Foundation Trust was available for telephone advice at weekends and phoned the unit daily to discuss the care of patients with acute stroke. Further stroke clinical support was available from University Hospital of North Staffordshire NHS Trust daily.

3 Nursing staff did not yet have the competences expected for their work on the Acute Stroke Unit and a healthcare professional with competences in swallowing screening was not on each shift. Reviewers were told that approximately 30% of nursing staff had achieved the expected competences. Nursing staff were committed to addressing this issue but the timelines for expected progress were not clear.

Only 0.3 wte Speech and language Therapy support was available and had no cover for absences. As a result, assessments could not usually take place within expected timescales.

4 The high risk TIA pathway at weekends was not clear. Reviewers were told that patients with high risk TIA were referred to University Hospital of North Staffordshire NHS Trust. It was not clear that staff in the Emergency Department and GPs were aware of this arrangement.

5 Arrangements for CT of patients with stroke outside normal working hours were not robust. Consultant to consultant referral was required, which may introduce delays, and the on call radiographers were not all competent in CT.

Further Consideration

1 It may be helpful to re-confirm plans for the further development of the Acute Stroke Unit, including timescales for achievement of nursing competences and involvement with neuro-radiology meeting. This will ensure that everyone involved, including senior managers within the Trust, is aware of plans and timescales and that the change to the admission thresholds for patients with acute stroke can be implemented with confidence when necessary progress has been made.

2 Reviewers were told that achievement of stroke targets in not included in Trust Board monitoring. This should be reviewed as part of plans for change to the admission threshold.

3 The 1:2 weekdays on call rota for consultant stroke specialists may not be sustainable. The Trust had plans to address this issue.

APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Anne Gregory	Specialist Nurse/Stroke Coordinator	Dudley Group of Hospitals NHS Foundation Trust
Corrine Ralph	Director	Birmingham, Sandwell and Solihull Cardiac and Stroke Network
Dr Deva Situnayake	Deputy Medical Director	Sandwell & West Birmingham Hospitals NHS Trust

WMQRS TEAM

Sarah Broomhead	Quality Manager	West Midlands Quality Review Service

APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No but', where there is real commitment to achieving a particular standard, than a 'Yes but' – where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

Table 1 - Percentage of Quality Standards met

Service	Number of Applicable QS	Number of QS Met	% met
Stroke and TIA – Acute Trust	54	41	76

MID STAFFORDSHIRE NHS FOUNDATION TRUST

Ref	Quality Standard	Met?	Comments
CC-201	There should be a nominated lead consultant and nominated lead nurse / allied health professional with responsibility for ensuring implementation of the Quality Standards for Services for People with Stroke (Acute Phase) and TIA.	Y	Leads were identified although none were based at Mid Staffordshire NHS Foundation Trust.
CE-501	Clinical guidelines should be in use in the Emergency Department covering: Patients with suspected stroke a. Assessment of patients with suspected stroke using ROSIER b. Immediate management c. Transfer of patients to an appropriate Thrombolysis Centre or Stroke Unit (QSAE-508) d. Referral information, including date and time of onset of symptoms, and date and time of first contact. Patients with suspected TIA a. Assessment, including undertaking an ABCD2 score b. Immediate management, including indications for aspirin or alternative anti-platelet agent c. Indications for referral to the Neuro-Vascular Assessment Service within 24 hours for high risk (currently ABCD2 score of 4 and above, multiple TIAs or minor stroke) or within seven days for low risk patients d. Referral information, including date and time of onset of symptoms and date and time when symptoms resolved e. Indications for admission f. Information to be given to patients and carers (QSCZ-102) if the patient is to be discharged before their neuro-vascular assessment.	N	Clinical guidelines were on the website but could not be accessed from the Emergency Department. Also, staff were not aware of the pathway.

Ref	Quality Standard	Met?	Comments
CN-101	Information should be offered to all patients and carers covering at least: a. Stroke, its causation and potential impact b. Investigations and treatment options available c. Research trials available (if any) d. Driving advice and DVLA notification e. Promoting good health, including diet, exercise and smoking cessation f. Stroke service staff and facilities available g. Who to contact with queries or for advice h. Symptoms and action to take if become unwell i. Access to benefits advice j. Support groups available k. Expert Patients Programme (if available) l. How to influence local services (QSCN-199) m. Where to go for further information, including NHS Direct and useful websites.	Y	
CN-102	Information about the following services should be easily available for patients and carers: a. Interfaith support b. Social services c. Interpreters d. Advocacy services.	Y	
CN-103	Information for patients and carers about the Stroke Service should be available covering, at least: a. What patients need with them b. Visiting times c. Who will be looking after the patient (for example, staff groups, uniform colours) d. How to find out what is happening e. Facilities for relatives f. Who to talk to about concerns g. Moving on from the Unit.	Y	
CN-104	Patients and, with the patient's agreement, relatives and carers, should have the information, encouragement and support to enable them fully to participate in decisions about their care.	Y	The therapy teams were strongly goal-orientated. Family meetings were held regularly.
CN-105	Patients being discharged home should be given a discharge letter. This letter should describe the condition, treatment given (if any) and future management plan. The contents of the letter should be discussed with the patient and, with the patient's agreement, their carer/s and a copy should be sent to their general practitioner.	Y	Good discharge planning arrangements were in place.
CN-199	The Stroke Service should have: a. Mechanisms for receiving feedback from patients and carers about the treatment and care they receive. b. Mechanisms for involving patients and carers in decisions about the organisation of the services.	Y	
CN-201	Thrombolysis Centres: A senior healthcare professional with specialist training and experience in stroke diagnosis and stroke thrombolysis should be available on site at all times.	N/A	

Ref	Quality Standard	Met?	Comments
CN-202	Thrombolysis Centres: A consultant stroke specialist should be available at all times.	N/A	
CN-203	Stroke Units: A consultant stroke specialist should be available on weekdays. A senior member of the stroke team should be available on all days when emergency admissions are accepted and the following day.	N	See main report.
CN-204	An Acute Stroke Unit should be available, staffed by nurses and HCAs with appropriate competences in care of patients with stroke. The competence framework should cover at least: a. Management of acutely ill and deteriorating patients b. High dependency care c. Swallowing screening d. Complications associated with stroke thrombolysis (Thrombolysis Centres only) e. Mobilisation f. Tube feeding.	N	See main report.
CN-205	At least one healthcare professional on each shift should have competences in swallowing screening.	N	See main report.
CN-206	At least one nurse on each shift should have competences in the management of acutely ill and deteriorating patients.	N	See main report.
CN-207	A member of staff with responsibility for coordination and for liaison with other services should be available and there should be arrangements for cover for this role.	Y	
CN-208	There should be a training and development plan for all members of the Stroke Team. The competences expected of each role should be identified and the plan for achieving and maintaining these competences described.	Y	A training plan was in place but the timescales for its implementation were not clear.
CN-301	CT scanning should be available on-site at all times. The service should be staffed by healthcare professionals with training and expertise in performing and interpreting brain CT scans and should meet The Royal College of Radiologists Standards for quality assurance of CT.	Y	See main report about difficulty in accessing CT outside normal working hours.
CN-302	The following services should be available daily: a. Physiotherapy b. Speech and language therapy (for both swallowing assessment and communication) c. Occupational Therapy	N	An 'on call' physiotherapy and OT service at weekends was due to start in January 2012.
CN-303	The following services should be available for patients with stroke: a. Dietetics (including staff with competences in nutritional screening) b. Psychological support c. Social work.	Y	
CN-304	Level 3 critical care facilities should be available on the same hospital site.	Y	

Ref	Quality Standard	Met?	Comments
CN-501	Clinical guidelines on the management of patients with stroke should be in use covering: a. Clinical assessment, including assessment of cognitive and perceptive problems b. Choice of imaging, including indications for CT, MRI, carotid Doppler and more complex imaging investigations c. Indications for thrombolysis or early anticoagulation treatment d. Other investigations e. Pharmacological treatment, including aspirin or alternative anti-platelet agent f. Intensity of daily therapy g. Indications and arrangements for referral to vascular services for consideration of carotid endarterectomy h. Indications and arrangements for referral to neuro-surgery i. Indications for referral to critical care j. Indications for referral to lifestyle management services (dietician, smoking cessation, psychology).	Y	
CN-502	Thrombolysis Centres: A thrombolysis protocol should be in use covering: a. Delivery and management of thrombolysis b. Management of post-thrombolysis complications.	N/A	
CN-503	Clinical guidelines should be in use covering the immediate management of patients with: a. Intracerebral haemorrhage b. Sub-arachnoid haemorrhage c. Arterial dissection d. Central venous thrombosis.	Y	
CN-504	Clinical guidelines should be in use covering the management of: a. Hypertension b. Obesity c. High cholesterol d. Atrial fibrillation e. Diabetes f. Fever	Y	
CN-505	The following protocols should be in use: a. Recognition of deteriorating patients and transfer to intensive care b. Provision of high dependency care, including communication with critical care services c. Prevention and management of venous thrombosis d. Nutrition and feeding, including tube feeding e. Mobilisation f. Physiological and neurological monitoring.	Y	
CN-506	Discharge planning guidelines should be in use covering, at least: a. Discharge to Stroke Unit closer to the patient's home (Thrombolysis Centres only) b. Discharge to stroke rehabilitation facility c. Discharge home with support from specialist stroke rehabilitation services d. Communication with the patient's GP.	Y	The discharge planning was very good. There were difficulties in accessing early supported discharge in some areas (especially the Seisdon Peninsular).

Ref	Quality Standard	Met?	Comments
CN-598	A protocol on driving advice should be in use, covering establishing the type of licence and giving appropriate advice on DVLA notification.	Y	
CN-599	The stroke service should be aware of local guidelines for end of life care.	Y	
CN-601	An alert system should be in use which ensures rapid availability of clinical and imaging staff for assessment of eligibility for thrombolysis.	Y	
CN-602	An operational policy should be in use which ensures: a. Brain imaging for urgent patients, including those where thrombolysis is being considered, within 30 minutes of admission and, at the latest, within 60 minutes of admission b. Thrombolysis within 60 minutes of admission in appropriate patients (Thrombolysis Centres only) c. Brain imaging for all patients, within four hours of admission and, at the latest, within 24 hours of admission d. Swallowing screening within four hours of admission and prior to administration of any drinks, food or oral medication e. Specialist swallowing assessment within 24 hours of admission (if indicated on admission screening) f. Rehabilitation assessment by physiotherapy, speech and language therapy and occupational therapy (if required) within 24 hours of admission g. Assessment by other members of the specialist rehabilitation team (QSCN-303), if required, within five days of admission h. Referral for carotid endarterectomy within one week of onset of symptoms, if indicated i. Care plans are in place for all patients and reviewed regularly.	Y	
CN-603	A ward round or review of all patients by a senior member of the stroke team should take place daily.	N	Ward rounds were undertaken daily. At weekends a consultant was on call and telephoned the ward daily to discuss any patients with stroke. A stroke consultant from UHNS was also available for advice.
CN-604	A multi-disciplinary team meeting to review the care of patients with stroke should be held at least weekly involving at least: a. Stroke specialists b. Stroke coordinator (QSCN-207) c. Rehabilitation services (QSCN-302 & CN-303).	Y	
CN-605	A neuro-radiology multi-disciplinary team meeting should be held at least weekly.	N	The team did not participate in neuro-radiology meetings but there were plans for this to change.
CN-609	Arrangements should be in place for multi-disciplinary discussion of patients' suitability for surgery involving a stroke specialist, radiologist, vascular surgeon and stroke coordinator or lead nurse.	N	Arrangements for formal discussion were not yet in place.

Ref	Quality Standard	Met?	Comments
CN-701	The service should have a system of monitoring time from onset of symptoms and progress through the patient pathway for all patients.	Y	
CN-702	There should be regular collection of the national data set and monitoring of activity and outcome indicators.	Y	Data collection arrangements were good. (See main report).
CN-703	The service should have an annual programme of audit of compliance with evidence-based guidelines.	Y	
CN-704	The service should have arrangements for review of complaints, positive feedback, morbidity, mortality and critical incidents. This should include review of patients where thrombolysis was indicated but not administered within three hours of onset of symptoms.	Y	
CN-705	The service should produce an annual report summarising activity, compliance with quality standards and clinical outcomes. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report.	N/A	The service has not been operational for 12months.
CN-706	The service should be an active member of the West Midlands Stroke Research Network.	Y	
CN-707	The service should offer an educational session on the assessment of patients with stroke to local GPs at least annually.	Y	The team was aware that more primary care training was needed about the change in pathway.
CN-708	Thrombolysis Centres: The service should coordinate an educational session for referring Stroke Units on the assessment and treatment of patients with stroke at least annually. This session should include: a. Review of the care of patients where thrombolysis was indicated but not administered within three hours of onset of symptoms. b. Review of arrangements for discharge of patients to local Stroke Units.	N/A	
CN-709	Stroke Units: The service should participate in the educational session run by the Thrombolysis Centre to which patients are usually referred.	Y	
CN-799	All policies, procedures and guidelines should comply with Trust document control procedures.	N	The main protocols and guidelines met the QS. Some of the detailed documents had not yet been through the approval process.

Ref	Quality Standard	Met?	Comments
CP-101 DVLA	Information should be offered to all patients with a confirmed TIA covering at least: a. Transient Ischaemic Attack, its causation and potential impact b. Investigations and treatment options available c. Research trials available (if any) d. Driving advice and DVLA notification e. Promoting good health, including diet, exercise and smoking cessation f. Symptoms and action to take if become unwell g. Follow-up arrangements h. Who to contact with queries or for advice i. How to influence local services (QSCP-199) j. Where to go for further information, including NHS Direct and useful websites.	Y	
CP-102	All patients with a confirmed TIA should have their management plan discussed with them. Patients should be offered a written, individual management plan. Arrangements should be in place to ensure a copy of this plan is received by the patient's GP within one week of the neuro-vascular assessment.	Y	
CP-103	Information for patients about interpreter services should be available.	Y	This information could be more widely publicised.
CP-199	The Neuro-Vascular Assessment Service should have: a. Mechanisms for receiving feedback from patients and carers about the treatment and care they receive. b. Mechanisms for involving patients and carers in decisions about the organisation of the services.	Y	
CP-201	A Neuro-Vascular Assessment Service should be available daily with at least: a. A healthcare professional who is a member of the stroke team and has competences in neurovascular assessment b. Ultrasound duplex devices and a member of staff with competences in vascular ultrasound c. A consultant stroke physician available for advice.	Y	See main report about the need for greater awareness of the high risk TIA pathway at weekends.
CP-301	MRI / MRA with diffusion weighted imaging and gradient echo sequences should be available within 24 hours for patients at high risk of subsequent stroke and within seven days for those at lower risk. CT / CTA should be available for patients where MRI is contra-indicated.	N	MRI was not available 24/7. the MRI machine at Cannock was not suitable for patients with acute stroke.
CP-302	Access to lifestyle management services, including dietician, smoking cessation and psychology services, should be available.	Y	

Ref	Quality Standard	Met?	Comments
CP-501	Clinical guidelines should be in use within the Neuro-Vascular Assessment Service covering: a. Clinical assessment b. Choice of imaging, including indications for carotid Doppler, CTA and MRA c. Other investigations, including blood tests, echo and 24 hour ECG d. Pharmacological treatment, including initiation of aspirin, statins and blood pressure management (see note 2) e. Indications for admission f. Indications for referral to lifestyle management services (dietician, smoking cessation, psychology) g. Indications for referral to vascular services for consideration of carotid endarterectomy h. Indications for referral to cardiology services, including arrhythmia services. i. Arrangements for one month follow up of well-being, cognitive impairment and impact on work (if undertaken by Neuro-Vascular Assessment Service).	Y	See main report about the need for greater clarity of the high risk TIA pathway at weekends.
CP-598	A protocol on driving advice should be in use, covering establishing the type of licence and giving appropriate advice on DVLA notification.	Y	
CP-609	Arrangements should be in place for multi-disciplinary discussion of patients' suitability for surgery involving, at least, a stroke physician, radiologist and vascular surgeon.	N	Arrangements were not yet in place.
CP-701	The service should offer an educational session on the assessment of TIA to local general practitioners at least annually.	N	Staff were aware that more work on this was needed.
CP-702	There should be regular collection of data and monitoring of activity and outcome indicators.	Y	
CP-703	The service should have an annual programme of audit of compliance with evidence-based guidelines.	Y	Arrangements for audit were in place. The Trust should ensure the ongoing audit plans are clear and are implemented.
CP-704	The service should have arrangements for review of complaints, positive feedback, morbidity, mortality and critical incidents.	Y	
CP-705	The service should produce an annual report summarising activity, compliance with quality standards and clinical outcomes. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report.	N/A	The service commenced in June 2011.
CP-799	All policies, procedures and guidelines should comply with Trust document control procedures.	Y	