Review of Care of People with Stroke, Transient Ischaemic Attack (TIA) and Rehabilitation Pathway

The Royal Wolverhampton NHS Trust

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8831

Contents

Introduction 3

About Quality Review Service 3

Acknowledgments 3

Care of People with Stroke, Transient Ischaemic Attack (TIA) and Rehabilitation Pathway 4

Introduction 4

Trust-wide Stroke Service 4

Hyperacute Stroke Unit and Acute Stroke Unit – New Cross Hospital 8

Stroke Rehabilitation 11

West Park Rehabilitation Hospital 12

Cannock Hospital, Fair Oak Rehabilitation Ward 14

APPENDIX 1 Membership of Visiting Team 16

APPENDIX 2 Compliance with the Quality Standards 17

Introduction

This report presents the findings of the review of Services for People with Stroke or Transient Ischaemic Attack (TIA) and Rehabilitation Pathway that took place on 26th and 27th March 2019. The purpose of the visit was to review compliance with the following Quality Review Service (QRS) Quality Standards:

- Quality Standards for Services for People with Stroke or Transient Ischaemic Attack and Rehabilitation Pathway. Version 2, 2017

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care 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 and information available to the reviewers at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Any immediate risks identified include the Trust's response to the report of the risk and QRS' s response to any actions taken to mitigate the risk. Appendix 1 lists the visiting team that reviewed the services in Wolverhampton and South Staffordshire health economies. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- The Royal Wolverhampton NHS Trust
- NHS Wolverhampton Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Wolverhampton Clinical Commissioning Group.

About Quality Review Service

QRS is a collaborative venture between NHS organisations 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 QRS is available on www.wmqrs.nhs.uk

Acknowledgments

Quality Review Service would like to thank the staff and service users and carers of Wolverhampton and South Staffordshire health economies 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.

Care of People with Stroke, Transient Ischaemic Attack (TIA) and Rehabilitation Pathway

Introduction

This review looked at the care of people admitted with stroke or transient ischaemic attack (TIA), the acute phase of care, and the stroke rehabilitation pathway. Reviewers visited the hyperacute and acute stroke ward at New Cross Hospital, and the rehabilitation services based at West Park Rehabilitation Hospital and Fairoak Ward at Cannock Hospital. The inpatient rehabilitation and community stroke services provided by Walsall Healthcare NHS Trust were not included in this review. Reviewers met with a range of patients and staff during the course of the visit.

Reviewers acknowledged the significant change that had taken place over the last 12 months, with the reconfiguration of stroke services. From April 2018, a combined Hyperacute Stroke Unit (HASU) and Acute Stroke Unit (ASU) service had been located on the New Cross Hospital site in Wolverhampton. The service had moved to a new ward area, C21, and the hyperacute and acute bed numbers had increased from 23 to 39. The consultant stroke physician establishment had been increased from 4 to 7.2 wte, with plans to increase this to 8 wte, and, the nursing, therapy, dietetics, pharmacy technician establishments had also been proportionally increased to cover the increased activity expected. At the same time, the Walsall Healthcare NHS Trust stroke service had merged with The Royal Wolverhampton NHS Trust stroke service. At the time of the visit, the service had cared for 850 stroke patients, slightly fewer than the annual forecast of between 950 and1,000 patients.

A clear pathway was in place with the West Midlands Ambulance Service to ensure that all patients who were suspected of having had a stroke in the community (Wolverhampton, Walsall, and South Staffordshire) were transferred to the New Cross Hospital ED and then admitted directly to the ASU/HASU if required.

Patients who presented directly to the Walsall Hospital ED were urgently transferred to New Cross Hospital and inpatient to inpatient transfers were undertaken following consultant to consultant referrals.

Staff who met the reviewing team said that an average of five to six patients each day were admitted for suspected TIA, hyperacute stroke or acute stroke care. Following the acute phase of care, and depending on their home address, patients were then transferred for rehabilitation to inpatient services based at West Park Rehabilitation Hospital, Fairoak Ward at Cannock Hospital or, Walsall Manor Hospital, or to community services.

Early Supportive Discharge Teams were in place as well as Community Stroke Teams, in each locality.

Trust-wide Stroke Service

Stroke, TIA and stroke rehabilitation services were provided by committed and enthusiastic multi-disciplinary teams who had plans for the future development of services. Staff were aware of the problems facing the serivce and were working to address these. Patient feedback about care across all the stroke services visited was positive and patients who met with the visiting team were appreciative of the care they had received.

Reviewers met with two Wolverhampton based GPs who were also positive about the liaison and specialist advice available from the teams and felt that the pathway was working well.

Some comments in the Trust-wide section of this report apply to more than one service and are therefore not duplicated in other areas of the report.

Immediate Risk

1. **Access to a consultant stroke specialist at all times.**[1]

   A consultant stroke specialist was not available between the hours of 8pm and 8am daily to provide immediate access to expertise in stroke medicine. This is required for a service designated to receive emergency admissions for patients with a suspicion of a stroke or TIA and for the hyperacute and acute stroke unit.

   Patients attending the Emergency Department between the hours of 8pm and 2am were reviewed by a consultant in emergency medicine. Outside of 2am and 8am staff would access the on-call acute medical registrar. Neither arrangement provided appropriate expertise by a consultant with specialist experience in stroke diagnosis and stroke assessment.

   Staff who met the reviewers commented that the Emergency Department and stroke consultants could be contacted for advice, but the arrangements were not formalised and were therefore subject to availability and goodwill. The lack of appropriate cover by a consultant stroke specialist was highlighted on the Trust risk register, but at the time of the visit a solution to ensure that appropriate advice was available overnight had not yet been found.

Good Practice

1. The Trust and service had implemented a number of initiatives to help with recruitment and retention of the workforce:

   a. Integrated therapy provision had been introduced with some Band 4, 5 and 6 occupational therapist and physiotherapists rotating between the hyperacute and acute stroke ward and, the stroke rehabilitation services at West Park and Cannock.

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[1] **Trust Initial Response 9.5.19:** We would like to clarify that currently there is a formal overnight arrangement with the ED consultants who undertake stroke thrombolysis assessments on a 1 in 8 basis between 20:00-02:00. Between 02:00 -08:00 hours stroke thrombolysis is currently supported by the on-call ED consultant. They are also supported by a Stroke nurse 24/7. We agree that there is the need to have a specialist on call rota and have been actively trying to resolve this in recent weeks. With effect from Monday 3rd June 2019, the following has been agreed: The ED consultants will continue to help the Stroke team provide stroke thrombolysis cover from 2000hrs to 0200hrs, as they are on site during this time period. The significant and relevant change is that following discussion with all Stroke consultants, they have agreed to provide direct overnight stroke on call cover between 0200 and 0800hrs. There will be robust guidance in place for the overnight Stroke specialist nurse to follow as to when to contact the Stroke consultant on call (i.e. thrombolysis/thrombectomy patients or complex brain haemorrhage) so that minimises any knock-on effect to the daytime service currently provided by the current stroke consultant resource. We will need to monitor if there is a knock-on effect to the daytime service. The Stroke team will shortly be doing a 1 in 7 daytime on call rota (for thrombolysis) and 1 in 3 weekend rota (ward round, TIA clinic, thrombolysis provision) due to staff leaving the team. However, we are actively looking to how we can improve the service so that it remains sustainable in the shorter term and an attractive place to work in the medium term. In the longer term we are looking at the recruitment and training of ANPs to be able to do ward duties, TIA clinics and ultimately help with the thrombolysis and thrombectomy rota. We envisage that this will take at least 24 months to come to fruition.
QRS Initial Response 15.5.19: We have now considered your response with the Reviewers who consider that the actions taken do not fully mitigate the immediate risk identified for the following reason: The Trust at the moment is the second biggest stroke provider in the West Midlands seeing approximately 1000 patients after the centralisation of stroke services with Walsall Healthcare NHS Trust. The reliance therefore on the Consultant in Emergency Medicine and Stroke Specialist Nurse to provide cover between 8pm and 2am does not provide appropriate 24/7 cover by consultant stroke specialist for assessing patients needing hyperacute treatment decisions on thrombolysis and thrombectomy. The number of patients attending during this time is also likely to be low, which would also not provide the Emergency Department team with sufficient exposure to assess stroke patients for thrombolysis and thrombectomy and keep up to date with the assessment of patients. Therefore, the interim arrangement proposed between 8pm and 2am will not mitigate the risk and does not meet the national 24/7 service standard expected which was agreed as part of the reorganisation of stroke services across the region.

Trust Final Response 01.7.19 The Trust and the Stroke team accept the principle that there should be 24/7 cover by Consultant Stroke Specialists for assessing patients needing hyper acute treatment decisions on thrombolysis and thrombectomy, and following a review of job planning within the department, I am pleased to say that from 1st September 2019, there will be a full Stroke consultant cover, both during the day and out of hours (200.00hrs- 08.00hrs), Monday to Friday. The day time arrangements for Saturday and Sunday will continue to provide Consultant cover between 08.00hrs -20.00hrs, with the current arrangements remaining in place over night (20.00 -08.00hrs) until 1st December 2019, at which time the Stroke Consultant team will be providing full 24/7 cover for the 7 days of the week
QRS Final Response 12.7.19 We have now considered your response and can confirm that the actions, as described, will address the immediate risk once fully implemented.

b. A Trust-wide Clinical Fellowship Programme was running which provided opportunities for training, experience and career development for both medical and nursing staff.

c. A scheme for the development of Band 2 healthcare assistants had been introduced, to allow them to obtain competences to perform some patient observations, electrocardiograms (ECG) and bladder scanning.

2. The CaptureStroke® data collection and care performance improvement system had been implemented which enabled the real-time data collection of key timescales and metrics. Staff were able to access the password-protected system from any Trust computer. Reviewers were impressed with the service's approach to reviewing the performance data during the weekly HASU/ASU operational meeting and quarterly with rehabilitation teams. Data could also be uploaded quarterly direct to the Sentinel Stroke National Audit programme (SSNAP).

3. Staff reported that the stroke and TIA pathway for patients residing in the Walsall health economy was working well. Few delays were experienced in transferring patients either to one of the 16 designated stroke beds at Walsall Manor Hospital or home with support from the early discharge team. Reviewers were impressed with the progress, given the scale of the reconfiguration.

4. 'Trusted Assessors' were in place, which had helped reduce the numbers and waiting times of people awaiting discharge from the hospital back home or to another setting.

5. Stroke-specific competence frameworks were in place across all the sites for all levels of nursing, physiotherapy and occupational therapy staff.

Concerns

1. **Imaging and Diagnostics**

   Reviewers were concerned about the provision of imaging and diagnostics in place for the designated regional hyperacute stroke service based at the Trust for the following reasons: -

   a. Computed Tomography Angiography (CTA) was not available 24hours a day, as during the night there were insufficient trained radiographers able to provide a service, and there was reduced access to staff able to interpret the scans. This was resulting in delays in identifying patients who were suitable for transfer to the Royal Stoke University Hospital (University Hospitals of North Midlands NHS Trust) for potential thrombectomy.

   b. Reviewers were concerned that the service had insufficient capacity to deliver the number of CTA examinations for the number of patients presenting with a suspicion of stroke. Carotid CTA slots were limited during normal working hours. The team was in the process of determining the numbers of patients that would require scanning, and was looking to implement two dedicated CTA slots during the week to improve the timely referral of patients, who were suitable for vascular surgery. This issue would be compounded further if, in the future, CT perfusion is required to be available as part of the stroke thrombolysis and thrombectomy assessment.

   c. At weekends, only two slots for magnetic resonance imaging (MRI) were available.

2. **Access to Speech and Language Therapy**

   Insufficient speech and language therapy (S&LT) was available to cover the level of intensive therapy required for patients admitted to Ward C21, and for the ongoing rehabilitation of patients at West Park.

   On Ward C21 the speech and language team staffing included a 0.9 wte Band 7and one Band 6, and two days a week of an assistant practitioner (Band 5), who was also providing some cover at West Park.

West Park only had one part-time Band 7 speech and language therapist, and some cover from the assistant practitioner mentioned above, to support the rehabilitation of patients. The team had one Band 6 vacancy and there were plans for the Band 7 post to be a full-time job share in the near future.

Reviewers commented that approximately one third of patients admitted to a HASU or ASU or receiving ongoing rehabilitation would have dysphagia or swallowing difficulties. At the time of the visit the ratio of patients on Ward C21 requiring S&LT support was slightly higher, with 28 out of the 39 inpatients having dysphagia or swallowing difficulties.

At West Park the ward staff did not have competences in swallow screening and referred patients to the speech and language therapist to undertake this screening (see also concerns section for West Park). Reviewers were told that the assistant practitioner did not have training in the care of patients with dysphagia. The combination these circumstances would also have an impact on the workload for the Band 7 part-time speech and language therapist.

3. **Access to Dietetics**

   The services were funded for 0.45wte of a dietitian, whereas the recommended level of dietetic support 1.17 wte for the size of the acute stroke unit. Patients were referred through the Trust 'Safehands' system and referrals were prioritised within the dietician's caseload, with those patients requiring enteral feeding being high priority. Previously the dietetic service had been able to provide general support five days per week but, because of Trust-wide dietetic staff vacancies this was no longer possible. Access to a dietician was also limited for inpatients at West Park Hospital with the dietitian visiting the rehabilitation unit two days a week. The dietician was able to attend the weekly acute stroke multidisciplinary meeting (MDT) and would attend the MDT meeting at West Park when appropriate and if time allowed.

Further Consideration

1. A part time clinical psychologist (0.8 wte) with support from a Band 4 practitioner was in place to provide support for the whole stroke service. The Band 4 practitioner undertook some initial patient assessments and administrative work. In practice the psychologist was only able to provide an outpatient service at West Park, and did not have capacity to provide support to either the acute stroke or the stroke rehabilitation inpatient wards. The psychologist was also spending considerable time on administrative duties rather than clinical care.
2. For patients from Staffordshire 'Discharge to Assess'[2] was not available which was delaying the discharge of patients who were ready to go home or to a community setting. Staff were concerned that the progress made in the patients physical health could deteriorate because of the increase in length of stay.

Return to Index

[2] ***Discharge to Assess:*** *Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person (NHS England* Gateway Reference 05871)

Hyperacute Stroke Unit and Acute Stroke Unit – New Cross Hospital

General Comments and Achievements

Since the last peer review visit in 2010 considerable progress had been made. The number of consultant stroke physicians had increased from 2 to 7.2 wte (including two locum consultants), providing cover between the hours of 8am and 8pm, with two consultants covering the service at weekends. A stroke specialist nurse was also on site seven days a week between the hours of 8am and 8pm.

With the increase of beds on Ward C21 the majority of patients were admitted initially to the stroke unit rather than to other speciality wards.

There were good links with the Emergency Department and with Trust management.

Immediate Risk: See the Trust-wide section of the report

Good Practice

1. See also the Trust- wide section of the report
2. A strong research ethos was evident with the research team actively participating in a range of stroke related research trials. There were plans to develop a clinical academic role to increase involvement in research. Reviewers were particularly impressed that the service was the top recruiter in two trials.
3. **Education and training**
    a. Multidisciplinary training sessions were run on a weekly basis.
    b. The education and training programme and competences were in the process of being re energised. At the time of the visit the stroke education programme had been reintroduced after a four-year gap. The practice educator was working with staff to achieved higher levels of competences in the care of patients with a stroke.
    c. Ninety percent of ward staff had completed their mandatory training which was the highest percentage achieved for nine years.

Concerns

1. **Nurse Staffing for Ward C21**

    Reviewers considered that the ward nurse staffing levels for the 39 beds were insufficient for the number of patients and the level of therapeutic interventions delivered for the following reasons:-

    a. The ratio for the registered nurse to unregistered staff establishment for the HASU and ASU was 7:4 in the daytime and 5:4 at night. The thrombolysis specialist nurse was not supernumerary and in practice was often not available for clinical work on the ward.
    b. The nursing establishment had been based on four HASU beds being in operation, and the ability to deliver registered nursing care on a 1:2 patient ratio. Data showed that the number of patients requiring hyperacute stroke care often ranged between eight and ten patients daily, which, would equate to the requirement for at least four registered nurses for this group of patients. HASU patients were cohorted in bays of three with two additional side rooms, which reviewers considered made it more difficult to achieve the recommended nurse staffing levels.
    c. At the time of the visit the ward had 9.97 registered nurse vacancies. Existing registered nursing staff were working extra shifts (reviewers were told that they were often working up to 50hours a week) to provide cover because of the limited access to bank staff with appropriate competences in stroke care.
    d. Two bays were used to cohort patients with cognitive impairment, delirium or a higher risk of falls requiring more than a general level of observation, and these had additional staff. At the time of the

visit, as an interim measure, extra Band 2 healthcare support workers were rostered to work in these areas.

This issue would have been raised as an immediate risk to clinical safety and clinical outcomes, but at the time of the visit: -

i. the ward team had been able to cover staffing shortfalls with their own experienced nursing staff;

ii. audit data were available which showed that although direct patient care hours were low for the number of patients being cared for, the key performance measures that would indicate care was suboptimal, such as the number of patient falls, hospital acquired pressure sores and incidents, had not changed, which reviewers considered was credit to the dedicated and hardworking team;

iii. increasing the Band 6 establishment so that there were more career opportunities for existing Band 5 nurses had improved nurse retention on the ward;

iv. senior managers were working with the ward team to review the ward nursing staff establishment, including identifying the level of need for hyperacute stroke care and developing a plan for the thrombolysis specialist nurses to be supernumerary; and

v. the workload and staffing issues were documented on the Trust risk register.

2. **Stroke and TIA Pathway**

Other aspects of the pathway were of concern to the reviewers; for example: -

a. A thrombectomy pathway was in place, but at the time of the visit the infrastructure (both clinical and imaging) did not allow every patient presenting with hyperacute stroke to be assessed to see whether they would benefit from thrombectomy (see Trust-wide Immediate Risk and Concern 1 sections of the report for more detail).

b. Two consultants were on duty over the weekends to review patients, including post- thrombolysis patients. This equated to 12 PAs, but meant that the eight consultants (7.2wte) were effectively doing a 1:3 weekend rota.

c. Following the merger with the Walsall service, the level of junior medical staff had not been increased in proportion to the increase of beds and the transfer of the service. Staff who met the reviewers commented that discussions had been held with the West Midlands Deanery, but at the time of the visit there was a shortfall of approximately four junior medical staff available for middle grade cover for the unit. The shortfall resulted in consultant medical staff spending more time delivering care directly than leading the hyperacute and acute stroke service, which may not be the best use of their expertise and time.

d. Patient reviews undertaken six weeks following discharge from the unit did not include a review by a consultant stroke physician but were performed by the advanced nurse practitioners from the Community Stroke Teams. This meant that the prescription of drugs by the Community Stroke Team at the initial post discharge visit was overseen by the patient's GP rather than a member of the stroke team. Reviewers were also concerned that, as the patient reviews were not consultant/medically led, opportunities were being lost to review and optimise the treatments commenced during the acute stroke phase and to address secondary prevention issues at this stage of the patient's recovery.

Further Consideration:

1. At the time of the visit the service was seeing approximately 2000 patients with a suspicion of a TIA, and providing a seven-day consultant-led service with specialist nurse support. As the ABCD2 risk assessment score was used as part of the primary care referral process, a large number of patients, a significant number of whom would not require further assessment or treatment, were booked into a TIA clinic for initial

assessment. Reviewers considered whether, if the system was 'open access' and patients were initially triaged by a specialist nurse, more clinically appropriate confirmed TIA patients could be seen in the clinic by the consultants, thus maximising medical staff time. Auditing the number of patients and subsequent diagnoses may also be useful in determining the level of future capacity for the TIA clinics.

2. A service level agreement was not yet in place to enable patients to be repatriated to Walsall if, following assessment, a short inpatient stay was indicated. Patients were cared for on the unit and then discharged home. Whilst the reviewing team understood the rationale of avoiding patients from Walsall being transferred back to Walsall for admission and multiple clinical handovers, this aspect of the patient pathway may not be sustainable in the future if the number of patients requiring hyperacute stroke care increases.

3. Reviewers observed the morning 'huddle', which was attended by a number of staff; however, the process appeared to be an update of what was already planned, with little input from those attending, apart from the lead consultant, nurse and therapist. It may be helpful to review the functioning of this meeting.

4. Three consultants were allocated to the ward and each took a third of the ward, which included new patients. It was not clear whether, if patients moved bed areas during their stay, they would be seen by the same consultant. Reviewers were unsure why there was not a system in place with a 'consultant of the week' who would see all new stroke and TIA patients and a second consultant who would then be free to provide advice and take any calls from primary or secondary care.

5. Optimising the use of the stroke speciality beds may benefit from review, as on the day of the visit one patient was awaiting transfer to the stroke unit despite two beds being available and other beds due to be available later in the day.

6. At the time of the visit there were 85 beds available for the care of stroke patients, comprising 39 acute beds on the New Cross site and 46 rehabilitation care beds (24 in West Park, 16 in Walsall, 6 in Cannock), which reviewers considered was high for approximately 1,000 patients per year. As the new pathway had been operational for a year, it may be helpful to look at opportunities to review the pathway and bed base.

7. Rehabilitation facilities on the ward were limited and may not be conducive to promoting rehabilitation as activity in the unit increases. The gym area only had one plinth, and access to the rehabilitation kitchen was via the gym so was difficult if the gym was in use. Some of the bed areas were not wide enough to enable the use of specialist chairs.

8. The signage for side room 1 would benefit from review to improve the privacy and dignity of patients who were admitted to this room. The layout of the room meant that if the small room door was open, the room appeared from the main ward area to be a corridor, with the patient's en-suite facility appearing to be a ward toilet. Staff told reviewers that there had been a number of occasions on which patients and visitors had entered the patient's side room by mistake.

9. Therapy staff had systems in place for goal setting, and held long-term goal setting meetings. However, from observation and the documentation seen at the time of the visit it was not clear that the processes, including the aim of interventions, were fully embedded in practice. Patients who spoke to reviewers were also not aware of their goals (which may be because of the term used), and therapy interventions and plans were not always aligned to patient goals, making it more difficult to review progress and implement appropriate plans as a result. Reviewers considered that more focussed work with staff around goal setting in clinical practice may, perhaps, be helpful.

Return to Index

Stroke Rehabilitation

General Comments and Achievements

Outpatient and inpatient stroke rehabilitation was provided at West Park Hospital (24 beds), primarily for residents of Wolverhampton and in Fairoak Ward (6 beds and 21 for the care of the elderly) at Cannock Chase Hospital for South Staffordshire residents. Residents from the Walsall area were transferred back to one of the 16 inpatient rehabilitation beds at Walsall Manor Hospital or discharged under the care of the Community Stroke Team. Patients with complex neurological conditions were also admitted under the care of the regional neurological rehabilitation ward (10 beds) based at West Park.

The Stroke Early Supportive Discharge team (ESD) was based at West Park, and included stroke therapists and rehabilitation assistants. The team was commissioned jointly with the local authority, and over 40% of patients discharged from inpatient care were seen by the team.

Community Stroke Teams covered the Wolverhampton, Walsall and Cannock areas. Each team included a stroke coordinator, a physiotherapist, two occupational therapists and a registered nurse. The Wolverhampton team covered three localities across Wolverhampton. The team undertook patient reviews for all stroke patients within six weeks of discharge from hospital up to one year after discharge. The Community Stroke Team acted as the single point of contact for stroke survivors, and also ran a TIA review clinic.

Reviewers visited the rehabilitation facilities at both West Park Rehabilitation Hospital and Cannock Hospital, and met with patients and staff including volunteers and representatives from psychology, the stroke ESD team and the Community Stroke Teams.

At both West Park and Fairoak Ward staff who met with the reviewing team were extremely enthusiastic and positive.

Return to Index

West Park Rehabilitation Hospital

Good working relationships with community and rehabilitation staff were evident throughout the visit. Patient feedback was very positive, and patients and families were appreciative of the care and ongoing support provided by the staff. Ward staff also liaised with colleagues on Fairoak Ward on a daily basis.

Staff-grade cover was available Monday to Friday and patients were reviewed by a consultant in stroke medicine twice a week. Out of hours, ward staff would liaise with a member of the on-call medical team. Staff had competences to give intravenous antibiotics and commence subcutaneous fluids and one nurse had started the nurse prescribers course.

Good Practice

1. See also the Trust-wide section of the report.
2. Reviewers were impressed with the role of the volunteers who were available to support patients. The 'buddy' system, which was highly appreciated by patients, had been established for a number of years, and volunteers would also visit patients at home.
3. Fundraising activities and support from staff and volunteers had meant that the tricycle club could meet regularly and take advantage of the local parks around the hospital. Art classes were also held. Staff had also been able to negotiate good subscription rates for patients who wished to join the local gym.
4. At West Park the ward management team had worked hard to recruit to vacant posts and at the time of the visit only had one 0.5wte Band 5 vacancy. Processes were also in place whereby a six-monthly review of staffing took place with the executive team and, as part of these meetings, ward management and senior nurses were able to present any cases for change.
5. Competences for non-qualified staff had been developed, and the team was working with the local university to implement an accreditation process.
6. The ESD team response rate was very good and the team was able to see patients within 24hours of referral, Monday to Friday.

Immediate Risk: None

Concerns

1. **Competences in Swallow Screening.**

   Staff at West Park did not undertake any initial swallow screening. Reviewers were told that this was because patients who were previously stable may have developed other co-morbidities which would require medical assessment. Patients would be referred to the S&LT for a full swallow assessment, but such assessments could only take place Monday to Friday. Outside these times, staff would discuss with the on-call medical team at New Cross, and there was the potential for patients to be transferred for assessment. Reviewers were concerned that patients would not be able to have oral fluids until advice was sought, and that for some patients this could result in inappropriate readmission to the acute hospital.

2. **Vocational Rehabilitation**

   The limited capacity within the service meant that patients who were in employment were prioritised for support. Limited access for vocational rehabilitation was available for patients who would be able to work with vocational support but were not in employment. Reviewers were concerned that there could be an increasing number of patients of working age who were not getting access to vocational rehabilitation.

3. **Access to Outpatient Occupational Therapy**

The service did not have a clear service profile that included referral criteria. At the time of the visit, new patients were waiting five months to be seen by the outpatient occupational therapy service. Reviewers were met with staff were told that any patient who had previously had a stroke could be referred to the outpatient service, which was contributing to longer waiting times.

4. **Length of Stay**

   Reviewers observed an MDT and from discussions with staff were not assured that the patients length of stay was being actively managed. Not all patients had an expected date of discharge, and some patients who spoke to the reviewers were unclear why they were still inpatients. Reviewers were concerned that one patient had a length of stay of 50 days and one a length of stay of 100 days.

Further Consideration

1. The outpatient and day hospital provision provided patients with access to a number of activities but some of the groups had patients who had attended for over a year. Reviewers considered that further work on enabling patients to be confident in accessing other community interest groups should be encouraged, especially as this model of day care may not be sustainable in the future. Reviewers were unable to see a policy or agreed process for 'letting go'.
2. The stroke coordinators had approximately 600 patients on their caseload and would see patients at three, six and twelve months. However, some patients remained on their caseload for years rather than being referred to local, non-clinical services (social prescribing).
3. Nurse led discharge was not yet in place but was being considered. Implementing nurse-led discharge would help in reducing length of patient stay and freeing up beds more quickly.
4. Reviewers acknowledged that a number of new staff had recently been appointed and that supporting new staff to complete the relevant training and competences in stroke care would be particularly important to ensure that sufficient staff with competence were on duty at all times.
5. Reviewers were impressed that the University of Wolverhampton provided accreditation for therapy staff who had completed competence assessments, but staff who met the reviewing team were told that the cost per member of staff to be accredited by the university had increased from £60 to £600, which meant that achieving accreditation had become prohibitively expensive.

Return to Index

Cannock Hospital, Fair Oak Rehabilitation Ward

General Comments and Achievements

Stroke rehabilitation on Fairoak Ward was provided by committed and enthusiastic staff. Staff were very positive about the progress that the service at Cannock was making to provide a more comprehensive stroke rehabilitation service. One member of staff told reviewers "It's a good time to be on the ward". Good relationships with community staff were evident and staff would liaise with colleagues at West Park on a daily basis. Reviewers met with patients on the ward and feedback was very positive. Patients and families were appreciative of the care and on-gong support provided by staff.

Fairoak Ward was a 27-bedded mixed rehabilitation ward with six designated beds for stroke rehabilitation. The other beds were designated for the care of the elderly, with one bed for rheumatology. Medical cover was, in the main, provided by a consultant geriatrician on site. Nurse staffing was appropriate, with ward staff covering shortfalls through additional bank shifts. At the time of the visit, there were six patients with a stroke diagnosis on the ward. Staff told reviewers that this was a low number and that the usual number of stroke patients ranged from six to fourteen.

Reviewers viewed the facilities and met with a range of nursing and therapy staff. Reviewers did not meet with any representatives from the speech and language service (which was commissioned from another provider), but were told that there were no issues in accessing appropriate support for patients.

The ward used an e-roster system to manage nurse staffing. Plans were in place to cover shifts using the existing nursing establishment through the Trust 'bank'. Reviewers were told that few shifts needed to be covered by bank staff who were not from the stroke ward.

Immediate Risk: None

Good Practice

1. See also Trust-wide section of the report
2. Reviewers observed the morning ward 'huddle' meeting, which demonstrated a professional approach to planning. Ward staff had documented the approach and published the article for use across the Trust.
3. Three members of staff had been trained in podiatry to help improve patients foot health. Staff were planning to support a targeted group of ward inpatients over the next 12 months and measure the impact of this additional intervention. If it was successful, they would roll out this intervention to a wider patient group.
4. Occupational therapists were working as an integrated team covering neurological conditions and stroke rehabilitation. Staff had competences in managing both types of patient. Physiotherapists told reviewers that there were dedicated staff with competences for caring for patients with neurological conditions based on the day ward and a dedicated team with competences to manage the ward-based patients. Reviewers considered that both models worked well for the service.

Concerns: None

Further Consideration

1. Staff who met with the reviewers commented that there had been a significant number of falls amongst some patient groups, with 12 incidences of patient falls in the last month. Staff told reviewers that they moved patients at risk of falls into areas where staff could observe them more closely, and that no particular themes could be identified among the reasons for the falls. The issue was being monitored by the ward and senior management team.

2. Reviewers heard that feedback from relatives of patients admitted to Cannock Hospital from south of Wolverhampton had identified that they found it difficult to travel to visit the patient. The transport service between New Cross and Cannock Hospital could be used by visitors, although some staff who met with the reviewing team thought that the service could only be used for staff and patients.

3. Specialist stroke physiotherapists told reviewers that they would benefit from bringing all the stroke patients into one area (known as cohorting) to enable them to manage the workload better. Nurses told the review team that they tried to bring stroke patients together where possible but that, because of, the design of the ward and the different specialities admitted, they cohorted patients based on risk and need rather than condition.

4. The ward sister commented that staff were moving towards goal setting with patients and including the relatives in this conversation. Staff were beginning goal setting within the first week of admission as a plan to support discharge. Therapy staff commented that their professional input was increasingly sought to support discharge. The Community Stroke Team were also invited to meet the patients as part of early planning for discharge, so that patients were familiar with the community team. Reviewers supported this initiative.

Return to Index

APPENDIX 1 Membership of Visiting Team

Visiting Team		
Pete Carr	Lead Nurse - Stroke	University Hospitals Birmingham NHS Foundation Trust
Seema Gudivada	Associate Director of Therapies	Birmingham Community Healthcare NHS Foundation Trust
Jessica Harris	Therapy Manager, Occupational Therapy, Physiotherapy and Orthotics	University Hospitals of Derby and Burton NHS Foundation Trust
Susan Jinks	User representative	
Clare Jones	Neurorehabilitation Case Manager Speech and Language Therapist	NHS England-Midlands and East
Tracey Jones	Deputy Executive, Quality and Engagement	NHS Telford & Wrekin Clinical Commissioning Group
Judith Mansfield	Physiotherapist (Community)	University Hospitals Birmingham NHS Foundation Trust
Dr Indira Natarajan	Consultant Stroke Physician	University Hospitals of North Midlands NHS Trust

QRS Team		
Tim Cooper	Director	Quality Review Service
Sarah Broomhead	Assistant Director	Quality Review Service
Jane Shaw	Administrator	Quality Review Service

Return to Index

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 also 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

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of Applicable QS	Number of QS Met	% met
Acute Trust-wide – The Royal Wolverhampton Hospital	2	2	100
Stroke & TIA Services- New Cross Hospital Neurovascular Assessment Service Hyperacute Stroke Unit Acute Stroke Services	53	35	66
Specialist Stroke Rehabilitation Service West Park Neurological Hospital	43	25	58
Specialist Stroke Rehabilitation Service Fairoak Ward, Cannock Chase Hospital	34	27	79
Health Economy	132	89	67

Return to Index

Acute Trust-wide – The Royal Wolverhampton Hospital

Ref	Quality Standards	Met? Y/N	Reviewer Comments
CC-201	**Staff training** All clinical staff working in the Emergency Department, acute medical admission unit (or equivalent) and acute medical wards should have training in: a. Recognition of symptoms of stroke b. Immediate management of patients with suspected stroke, including transfer to a Hyper-Acute Stroke Unit	Y	
CC-501	**Stroke and TIA Guidelines** Clinical guidelines should be in use throughout the acute hospital covering: **Patients with suspected stroke:** a. Assessment of patients with suspected stroke using ROSIER b. Immediate management c. Transfer to a HASU, including escort arrangements and monitoring during transfer d. Referral information, including date and time of onset of symptoms, and date and time of first contact **Patients with suspected TIA:** e. Assessment f. Immediate management, including indications for aspirin or alternative anti-platelet agent g. Indications for referral for neuro-vascular assessment within 24 hours for high risk or within seven days for low risk patients h. Referral information, including date and time of onset of symptoms and date and time when symptoms resolved i. Indications for admission j. Information to be given to patients and carers if the patient is to be discharged before their neuro-vascular assessment.	Y	

Return to Index

Stroke & TIA Services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-101	**Service Information** Each service should offer patients and their carers written information covering: a. Organisation of the service, such as opening hours and clinic times b. Staff and facilities available c. How to contact the service for help and advice, including out of hours **In-patient services only:** d. What patients need with them e. Ward routine and visiting times f. Facilities for relatives g. Moving on from the Unit	N	Limited information was available that was 'aphasia friendly' or age appropriate. Information was not clear about 'g' moving on from the unit. However, the information that was provided for patients and carers was comprehensive and well written.	N	No information was available that was 'aphasia friendly' or age appropriate. The information that was provided for patients and carers was comprehensive and well written.	N	No information was available that was 'aphasia friendly' or age appropriate. The information that was provided for patients and carers was comprehensive and well written.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-102	**TIA Patient Information** 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. Sources of further advice and information	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-103	**Stroke Patient Information** Information should be offered to all patients with stroke and their 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. Symptoms and action to take if become unwell g. Access to benefits advice h. Support groups available i. Expert Patients Programme (if available) j. Long-term support available and how to access this k. Sources of further advice and information	N	Limited information was available that was 'aphasia friendly' or age appropriate. Stroke Association information was displayed in the ward area.	N	No information was available that was 'aphasia friendly' or age appropriate. Stroke Association information was displayed in the ward area.	N	No information was available that was 'aphasia friendly' or age appropriate. Stroke Association information was displayed in the ward area.
CN-104	**Communication Aids** Communication aids should be available to enable patients to participate as fully as possible in decisions about their care.	Y	However, reviewers were not clear if the services had access to ACT (Access to Communication Technology) the regional NHSE funded service for communication aid provision.	Y	However, reviewers were not clear if the services had access to ACT (Access to Communication Technology) the regional NHSE funded service for communication aid provision.	Y	However, reviewers were not clear if the services had access to ACT (Access to Communication Technology) the regional NHSE funded service for communication aid provision.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-105	**TIA Management Plan** All patients with a confirmed TIA should have their management plan discussed with them and should be offered a written copy of their 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		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-106	**Stroke Care Plan** Each patient and, where appropriate, their carer should discuss and agree their Care Plan, and should be offered a written record covering at least: a. Agreed goals, including life-style goals b. Self-management and support to achieve this c. Planned assessments, therapeutic and/or rehabilitation interventions, including information on medications d. Social care needs and how these will be met e. Housing needs f. Early warning signs of problems and what to do if these occur g. Planned review date and how to access a review more quickly, if necessary h. Who to contact with queries or for advice The Care Plan should be communicated to the patient's GP and to relevant other **services** involved in their care.	Y		N	The ward stroke rehabilitation plans seen at the time of the visit did not include 'b' self-management', 'g' planned review date or how to access a review if more quickly if necessary. Documentation seen did not include estimated date of discharge. From discussions with staff processes covering the requirements of the QS were in place.	N	The ward stroke rehabilitation plans seen at the time of the visit did not include 'b' self-management', 'g' planned review date or how to access a review if more quickly if necessary. Documentation seen did not include estimated date of discharge. From discussions with staff processes covering the requirements of the QS were in place.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-107	**Review of Care Plan** A formal review of the patient's Care Plan should take place as planned. This review should involve the patient, where appropriate, their carer, and appropriate members of the multi-disciplinary team. The outcome of the review should be communicated in writing to the patient's and their GP.	Y	Patient reviews were all undertaken by the Community Stroke Team at 3,6,and 12 months after discharge from the unit.	Y	Community Stroke Coordinators completed reviews and communicated the outcome to the patient's GP.	Y	Community Stroke Coordinators completed reviews and communicated the outcome to the patient's GP.
CN-108	**Training for Carers** Prior to the patient's discharge, carers should be offered training in the tasks and equipment needed to enable the patient to go home. Carers' confidence in these tasks and use of equipment should be assessed within 72 hours of the patient being discharged and, if necessary, additional training and support should be offered.	Y		Y		Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-196	**Discharge Plan** On discharge both from in-patient care and from stroke rehabilitation services, patients and their carers should be offered written information covering at least: a. Care after discharge b. Ongoing self-management c. Possible complications and what to do if these occur d. Long-term support available and how to access this e. Who to contact with queries or concerns	N	c' was not clear in the documentation seen. The 'My Journey ' booklet given to patients did not specify complications and what to do if these occurred. Who to contact with queries or concerns was also not clear as numbers for all services were listed on the plan. From discussions with the Stroke Coordinators, they would review all patients and provide verbal information as required.	N	c' was not clear in the documentation seen. The 'My Journey ' booklet given to patients did not specify complications and what to do if these occurred. Who to contact with queries or concerns was also not clear as numbers for all services were listed on the plan. From discussions with the Stroke Coordinators, they would review all patients and provide verbal information as required.	N	c' was not clear in the documentation seen. The 'My Journey ' booklet given to patients did not specify complications and what to do if these occurred. Who to contact with queries or concerns was also not clear as numbers for all services were listed on the plan. From discussions with the Stroke Coordinators, they would review all patients and provide verbal information as required.
CN-197	**General Support for Patients and Carers** Patients and carers should have easy access to the following services and information about these services should be easily available: a. Interpreter services, including British Sign Language b. Independent advocacy services c. Complaints procedures d. Social workers e. Benefits advice f. Spiritual support g. HealthWatch or equivalent organisation h. Relevant voluntary organisations providing support and advice	Y		Y		Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-198	**Carers' Needs** Carers should be offered information on: a. How to access an assessment of their own needs b. What to do in an emergency c. Services available to provide support	N	'Supporting a Stroke Survivor' leaflet was routinely issued, but not information covering local support and services for carers.	N	'Supporting a Stroke Survivor' leaflet was routinely issued, but not information covering local support and services for carers.	N	'Supporting a Stroke Survivor' leaflet was routinely issued, but not information covering local support and services for carers.
CN-199	**Involving Patients and Carers** The service should have: a. Mechanisms for receiving regular feedback from patients and carers about treatment and care they receive b. Mechanisms for involving patients and carers in decisions about the organisation of the service c. Examples of changes made as a result of feedback and involvement of patients and carers	Y		Y	See Good Practice section of the report about the use of volunteers.	Y	
CN-201	**Lead Clinician/s** A nominated lead clinician should have responsibility for staffing, training, guidelines and protocols, service organisation, governance and for liaison with other services. The lead clinician should be a registered healthcare professional with appropriate specialist competences in this role and should undertake regular clinical work within the service. Hyper-acute Stroke Units and Stroke Units should have both a lead consultant and lead nurse with these responsibilities..	Y		Y		Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-202	**NVA: Staffing** Neuro-vascular assessment should be available daily staffed by at least: a. A healthcare professional who is a member of the stroke team and has competences in neurovascular assessment b. A member of staff with competences in vascular ultrasound c. A consultant stroke physician available for advice.	N	A member of staff with competences in vascular ultrasound 'b', was not available at weekends.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services
CN-203	**HASU: Senior Medical Staffing** A doctor with specialist training and experience in stroke diagnosis and stroke assessment should be immediately available on site at all times.	N	As SA	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services
CN-204	**HASU: Consultant Availability** A consultant stroke specialist should be available at all times.	N	See the Trust-wide Immediate Risk section of the report. A consultant stroke specialist was not available between the hours of 8pm and 8am.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services
CN-205	**Acute Stroke Units: Consultant Availability** Acute stroke units should have: a. Access to a consultant with expertise in stroke medicine at all times b. Review of patients by a consultant with expertise in stroke medicine at least five days per week.	N	See the Trust-wide Immediate Risk section of the report	N/A	This QS is not applicable to stroke rehabilitation services	N/A	This QS is not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-206	**Staffing Levels and Skill Mix** Sufficient staff with appropriate competences in the care of people with stroke and stroke rehabilitation should be available for the: a. Number of patients usually cared for by the service and the usual case mix of patients b. Service's role in the patient pathway and expected timescalesThe skill mix of staff should include: i. medical staff ii. nursing staff Specialist rehabilitation team comprising staff with competences in: iii. physiotherapy iv. occupational therapy v. speech and language therapy (for both swallowing assessment and communication) vi. clinical neuro-psychologist or clinical psychologist vii. dietitian viii. orthoptics (rehabilitation services only) ix. social work (rehabilitation services only) x. support workers All staff should have time allocated in their job plan for work with the stroke service. Cover for absences should be available so that the patient pathway is not unreasonably delayed, and patient outcomes and experience are not adversely affected, when individual members of staff are away.	N	See the Trust-wide section of the report in relation to Speech and Language Therapy and Dietetic staffing. See main report in relation to Nurse staffing Occupational Therapy and Physiotherapy staff though 'ringfenced' to work on the unit were required to cover other specialities.	N	Insufficient Speech and Language was available for the number of patients and the level of therapeutic interventions required to support patients with dysphagia and swallow difficulties. Some dietetic support was in place but not integrated within the rehabilitation team. One neurological Occupational Therapist covered the community service. Insufficient psychology time was available to provide support to inpatients (Psychology 0.8wte and a band 4 assistant). Cover for the Staff Grade was not always timely as depended on the Middle-Grade Doctor being able to attend from New Cross. In practice staff would access advice from the medical staff based on the neuro rehabilitation ward. This QS was met for ward staffing. **Ward Staffing:** Registered Nurses to unregistered staff ratio was early shift 3: 4, late shift, 3:3, nights 2:2 with the option access additional staff to provide 1;1 care for patients. All day shifts had a Band 6 nurse on duty and senior Band 5 nurse on night duty. Recruitment to nursing vacancies had been achieved with a number of new staff due to commence. At the time of the visit there was only 0.7wte Band 5 vacancy . **Medical staffing:** A Staff Grade doctor covered the unit Monday - Friday. Out of hours staff could access the on-call medical team at New Cross hospital.	Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-207	**Service Competences and Training Plan** The competences expected for each role in the service should be identified. A training and development plan for achieving and maintaining competences should be in place.	Y		Y		Y	
CN-208	**In-patient Stroke Services: Nurse Staffing** Nurses and HCAs should have appropriate competences in care of patients with stroke including at least: a. Management of acutely ill and deteriorating patients (HASU & SU only) b. High dependency care (HASU & SU only) c. Swallowing screening (HASU & SU only) d. Complications associated with stroke thrombolysis (HASU only) e. Mobilisation f. Tube feeding g. End of life care	N	Although competences were in place, due to the number of nursing staff vacancies, the clinical educator had focussed staff achieving the basic skills of caring for patients with a stroke. Many staff had not yet completed higher level competences. Some staff also commented to the reviewers that they did not feel confident to practice at the higher level ('c' and 'd') whilst the ward staffing was under such pressure.	N	Due to the number of new starters not all nursing staff had completed competences in the care of patients following a stroke. Competency frameworks were in place for both ward and therapy staff and the ward manager had plans to review and further develop the ward competence framework. This QS was met for the therapy staff. a -d' were not applicable to the rehabilitation service.	Y	a -d' were not applicable to the rehabilitation service.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-209	**Swallow screening** At least one healthcare professional on each shift should have competences in swallowing screening.	Y		N	Ward staff did not undertake swallow screening. If staff had concerns, about patients the patients would be assessed by the Speech and Language Therapist (Monday to Friday. At weekends and out of hours staff would contact the on-call medical staff for advice.	N/A	There were only six rehabilitation beds and patients transferred for rehabilitation were medically stable.
CN-210	**Management of acutely ill and deteriorating patients** At least one nurse on each shift should have competences in the management of acutely ill and deteriorating patients.	Y		Y		Y	
CN-211	**Coordinator** 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		Y	Patient flow and stroke coordinators were in place.	Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-298	**Competences – All Health and Social Care Professionals** All health and social care professionals working in the service should have competences appropriate to their role in: a. Safeguarding children and/or vulnerable adults b. Recognising and meeting the needs of vulnerable children and/or adults c. Dealing with challenging behaviour, violence and aggression d. Mental Capacity Act and Deprivation of Liberty Safeguards e. Resuscitation	Y		Y		Y	
CN-299	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available.	Y		Y	However there was little administrative support for the Psychologist based at West Park.	Y	
CN-301	**Imaging for Patients with Stroke** Access to the following services should be available on-site at all times: a. Brain CT scanning b. CT angiography The services should be staffed by healthcare professionals with training and expertise in performing and interpreting CT scans and should meet The Royal College of Radiologists Standards for quality assurance of CT.	N	A healthcare professional with training and expertise in performing and interpreting CT Angiography was not available between the hour of 7pm and 7am.	N/A	This QS was not applicable to stroke rehabilitation services.	N/A	This QS was not applicable to stroke rehabilitation services.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-302	**Hyper-Acute and Acute Stroke – Support Services** 24/7 access to the following services should be available: a. MRI with stroke-specific sequences available within 24 hours for patients at high risk of subsequent stroke and within seven days for those at lower risk b. Vascular surgery **Access to Neuroscience Centre for:** c. Intra-arterial clot extraction (using stent retriever and / or aspiration techniques) d. Neurosurgery	N	The service had insufficient access to MRI at weekends. Reviewers were told that there were only two MRI slots available for stroke patients.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services
CN-303	**Other Support Services** The following services should be available for patients with stroke and TIA: a. Smoking cessation b. Ophthalmology c. Orthotics d. Equipment supply, including supply of specialist seating and assistive technology e. Neuro-psychology (if not part of core team) f. Specialist palliative care	N	In practice the Psychologist did not have capacity to provide support to the inpatient service. All other support services were in place.	Y		Y	
CN-304	**Critical Care** Level 3 critical care facilities should be available on the same hospital site.	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-401	**Ultrasound duplex devices** Ultrasound duplex devices should be available for all neuro-vascular assessments.	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-501	**Neuro-Vascular Assessment Guidelines** Clinical guidelines on neuro-vascular assessment should be in use covering: a. Clinical assessment b. Carotid imaging including**:** i. Choice of imaging, including indications for carotid Doppler, CTA and MRA ii. Ensuring imaging within 24 hours of symptoms for patients being considered for carotid endarterectomy iii. Reporting method c. Other investigations, including blood tests, echo and 24 hour ECG d. Pharmacological treatment, including initiation of aspirin, statins and blood pressure management 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. If indicated, carotid endarterectomy should be performed as soon as possible within 7 days of onset of symptoms where TIA has been confirmed. h. Indications for referral to cardiology services, including arrhythmia services. i. Arrangements for six week follow up of well-being, cognitive impairment and impact on work	N	The guidelines did not appear to include the latest recommendations for initial assessment as they advocated the use of the ABCD2 scoring system which reviewers commented was no longer used in their organisations.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-502	**Clinical Guidelines: Hyper-Acute Stroke Care** Clinical guidelines on the hyper-acute management of patients with stroke should be in use covering: a. Links with the ambulance service b. Clinical assessment, including assessment of cognitive and perceptive problems c. Choice of imaging, including indications for CT, MRI, carotid Doppler and more complex imaging investigations d. Indications for thrombolysis and/or thrombectomy (QS CN-503) e. Indications and arrangements for referral to the following services: i. vascular services for consideration of carotid endarterectomy ii. neuro-surgery for consideration of decompressive hemicraniectomy	N	Guidelines covered all but 'a' and 'b'.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-503	**Thrombolysis and Thombectomy Protocol** A thrombolysis and thrombectomy protocol should be in use covering: a. Delivery and management of: i. thrombolysis ii. combination intravenous thrombolysis and intra-arterial clot extraction iii. intra-arterial clot extraction, including arrangements for referral if not available on site b. Neurological and physiological monitoring after thrombolysis and/or thrombectomy c. Management of post-thrombolysis and post-thrombectomy complications	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-504	**Clinical Guidelines - Hyper-Acute and Acute Stroke Care** Clinical guidelines on the management of patients with stroke should be in use covering: a. Neurological and physiological monitoring b. Other investigations c. Pharmacological treatment, including aspirin or alternative anti-platelet agent d. Recognition of deteriorating patients and transfer to intensive care e. Provision of high dependency care, including communication with critical care services and indications for referral for critical care	Y	Reviewers suggested that the team may wish to review the format of the guidelines as they included hyperlinks to websites to access further advice. This meant accessing guidance more complicated and time consuming for staff who were not familiar with hyper acute and acute stroke care.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services
CN-505	**Clinical Guidelines: Other Conditions** 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. e. Vertebral artery disease f. Intracranial arterial disease g. Patent foramen ovale h. Cerebral venous sinus thrombosis i. Antiphospholipid syndrome	N	Guidelines covering 'f and 'g' were not available.	N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-506	**Clinical Guidelines: Underlying Conditions** Clinical guidelines should be in use covering: a. Hypertension b. Obesity c. High cholesterol d. Atrial fibrillation e. Diabetes f. Fever g. Carotid stenosis (symptomatic and asymptomatic), including referral to vascular surgery services Guidelines should cover secondary prevention as well as management of immediate problems.	Y		Y		Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-507	**Clinical Guidelines: All Stroke Services** The following guidelines should be in use: a. Prevention and management of venous thrombosis b. Prevention and management of other complications c. Neurological and physiological monitoring d. Swallowing assessment e. Nutrition and feeding, including tube feeding f. Mobilisation g. Pain management h. Intensity of daily therapy, including a minimum of 45 minutes of each therapy that is required for a minimum of 5 days a week for as long as they are continuing to benefit from it i. Screening for cognitive and mood changes within six weeks of onset of symptoms and six and 12 months thereafter j. Referral to lifestyle management services (dietician, smoking cessation, psychology)	Y		Y		Y	

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		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-508	**Rehabilitation Assessment** Guidelines should be in use covering: a. Stroke rehabilitation assessment measures to be used and recorded routinely b. Assessment of people with reduced motivation and engagement in rehabilitation c. Use of more complex assessment measures including: i. criteria for their use ii. competences required	Y	Data were collected for 'c', however the guidelines would benefit from review to be more specific about the use of more complex assessment measures.	Y	Data were collected for 'c', however the guidelines would benefit from review to be more specific about the use of more complex assessment measures.	Y	Data were collected for 'c', however the guidelines would benefit from review to be more specific about the use of more complex assessment measures.

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		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-509	**Rehabilitation Guidelines** Guidelines should be in use covering rehabilitation for: a. Loss of motor control b. Loss of sensation c. Gait retraining, including walking aids d. Balance improvement, falls risk assessment and falls prevention interventions e. Impaired tone (spasticity and spasm) and prevention and treatment of contractures f. Improving communication g. Swallowing problems h. Oral health problems i. Nutrition assessment and management j. Urinary and faecal incontinence k. Visual impairment l. Memory and cognitive impairment, including spatial awareness problems m. Attention and concentration problems n. Depression and anxiety o. Fatigue p. Sexual dysfunction q. Personal and extended activities of daily living r. Work and leisure activities	Y	National guidelines were in use and localised in the rehabilitation assessment framework used by the team. Staff who spoke to the reviewers were also very knowledgeable about the guidelines in use.	Y	National guidelines were in use and localised in the rehabilitation assessment framework used by the team. Staff who spoke to the reviewers were also very knowledgeable about the guidelines in use.	Y	National guidelines were in use and localised in the rehabilitation assessment framework used by the team. Staff who spoke to the reviewers were also very knowledgeable about the guidelines in use.

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		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-510	**Driving** A protocol on driving advice should be in use, covering establishing the type of licence and giving appropriate advice on DVLA notification.	Y		Y		Y	

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		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-598	**Discharge Planning Guidelines** Discharge planning guidelines should be in use covering at least: a. Criteria and arrangements for Early Supported Discharge for in-patients with stroke and mild to moderate disability, with treatment at home beginning within 24 hours of discharge b. Discharge to a Stroke Unit closer to the patient's home (HASU only) c. Discharge to a stroke rehabilitation facility d. Discharge home with support from specialist stroke rehabilitation services e. Follow-up after discharge from hospital care including: i. assessment by specialist stroke rehabilitation staff within 72 hours of discharge for all patients discharged home with residual stroke-related problems ii. assessment of carers' ability to cope with managing the patient at home and referral for carers' needs assessment f. Discharge from the stroke rehabilitation service Guidelines should be specific about: i. arrangements for clinical handover ii. communication with the patient's GP iii. referral for long-term support	N	Guidelines covering discharge to rehabilitation services were not yet in place. In practice staff who spoke to the reviewers were able to articulate the criteria and processes in place. All other aspects of the QS were met.	N	Guidelines covering discharge to rehabilitation services were not yet in place. In practice staff who spoke to the reviewers were able to articulate the criteria and processes in place. All other aspects of the QS were met.	N	Guidelines covering discharge to rehabilitation services were not yet in place. In practice staff who spoke to the reviewers were able to articulate the criteria and processes in place. All other aspects of the QS were met.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-599	**Care of Vulnerable People** Guidelines for the care of vulnerable adults should be in use, in particular: a. Restraint and sedation b. Missing patients c. Mental Capacity Act and the Deprivation of Liberty Safeguards d. Safeguarding e. Information sharing f. Palliative care g. End of life care	Y		Y		Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-601	**Operational Policy** An operational policy should be in use which ensures: **HASU & ASU:** a. A neuro-radiology multi-disciplinary team meeting is held at least weekly b. Arrangements for multi-disciplinary discussion of patients' suitability for surgery involving a stroke specialist, radiologist, vascular surgeon and stroke coordinator or lead nurse **All stroke services:** c. A multi-disciplinary team meeting to review the care of patients with stroke is held at least weekly involving at least: i. stroke specialists ii. stroke coordinator iii. specialist rehabilitation team d. Care plans are in place for all patients and reviewed regularly (all stroke services) e. Repatriation of patients following referral for intra-arterial clot extraction, neurosurgery or vascular surgery**.**	N	An operational policy was not yet in place covering the requirements of the QS. In practice processes were in place.	N	An operational policy was not yet in place. In practice process for 'c' and 'd' were in place for the rehabilitation services.	N	An operational policy was not yet in place. In practice process for 'c' and 'd' were in place for the rehabilitation services.
CN-602	**Early Supported Discharge Team MDT Meeting** The stroke Early Supported Discharge Team should hold a multi-disciplinary team meeting to review the care of patients at least weekly.	Y		Y		Y	

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-701	**TIA Data Collection** Collection of data on activity and monitoring of outcome indicators should be in place, including: a. Carotid imaging within 24 hours for patients being considered for carotid endarterectomy b. Carotid endarterectomy within one week of onset of symptoms, if indicated	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-702	**Stroke Data Collection** Patient pathway data should be collected including: **Hyper-acute stroke services:** a. Brain imaging for urgent patients, including those where thrombolysis is being considered, within 30 minutes of admission (at the latest, within 60 minutes of admission) b. Thrombolysis within 60 minutes of admission in appropriate patients **Acute stroke services:** 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. Rehabilitation assessment by at least one member of the specialist rehabilitation team (physiotherapy, speech and language therapy or occupational therapy) within 24 hours of admission, if required f. Assessment by any member of the specialist rehabilitation team, if required, within five days of admission g. Number of patients offered Early Supported Discharge h. Screening for cognitive and mood changes within six weeks of onset of symptoms and six and 12 months thereafter i. Follow-up six weeks after discharge home j. Follow up at least six months after onset of symptoms and at least annually thereafter **All stroke services:** k. Implementation of guidelines for nursing care of patients (QS CN-506) l. Provision of a minimum of 45 minutes of each therapy that is required at least five days a week for as long as the patient continues to benefit from it	Y	SSNAP and data was collected via CaptureStroke® data collection and care performance improvement system. Reviewers were impressed that feedback on performance was shared with the team on a weekly basis.	Y	SSNAP and data was collected via CaptureStroke® data collection and care performance improvement system . Data was shared with the rehabilitation teams every quarter.	Y	SSNAP and data was collected via CaptureStroke® data collection and care performance improvement system . Data was shared with the rehabilitation teams every quarter.

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-703	**National Audit Programme** The service should submit data to the Sentinel Stroke National Audit Programme and should regularly review national comparisons, including achievement of relevant NICE Quality Standards.	Y		Y		Y	
CN-704	**Research** The service should actively participate in stroke-related research.	Y	A strong research ethos was evident with the research team actively participating in a range of stroke related research trials.	Y		Y	
CN-705	**Primary Care Education** The service should offer an educational session on the assessment and care of patients with stroke and TIA to local GPs at least annually.	Y		Y		Y	
CN-706	**HASU: Network Review and Learning** The service should coordinate an educational session for linked 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.	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services

Ref	Quality Standards	New Cross Hospital		West Park Rehabilitation Hospital		Cannock Hospital	
		Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments	Met? Y/N	Reviewer Comments
CN-707	**Stroke Units: Network Review and Learning** The service should participate in the educational session run by the HASU from which patients are usually referred.	Y		N/A	This QS was not applicable to stroke rehabilitation services	N/A	This QS was not applicable to stroke rehabilitation services
CN-798	**Multi-disciplinary Review and Learning** The service should have multi-disciplinary arrangements for: a. Review of and implementing learning from positive feedback, complaints, outcomes, incidents and 'near misses'. This should include review of patients where thrombolysis was indicated but not administered within three hours of onset of symptoms b. Review of and implementing learning from published scientific research and guidance c. Ongoing review and improvement of service quality, safety and efficiency	Y		Y		Y	
CN-799	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures.	Y		Y		Y	

Return to Index