Quality Standards

For services for people with

Stroke and Transient Ischaemic Attack

Version 2.5

July 2021

These Quality Standards were developed in accordance with the International Standard ISO/IEC 17020:2012 - Conformity assessment – Requirements for the operation of various types of bodies performing inspection in line with our accreditation with UKAS as an Inspection Body (No 8831).

The Quality Review Service closed on 31st July 2021, UKAS have asked that the accreditation symbol now be removed.

The standards can be used until they reach their expiry date – June 2022.

V2	08.12.2017	Updated to incorporate latest guidance
V2.1	21.04.2020	Updated for rebrand to QRS
V2.2	02.12.2020	Section for Stroke and TiA services amended *(Telephone no. removed)* Added in addition to CQC that other regulatory frameworks are in use in the devolved nations. QS CN-499 re -added re IT systems and governance CN-601 amended to include use of systems and governance arrangements for virtual consultations
V2.3	14.12.20	Literature reviewed Inclusion of Enhanced ESD if commissioned Reference to ABCD screening removed Pathways amended to be specific about brain imaging Clarification of stroke specialist added to staffing QS Amend NVA support services
V2.4	11.01.21	Due to the Covid -19 pandemic, this suite of QS were reviewed in December 2020 with some changes and the date for a formal revision extended to June 2022.
V2.5	31.07.21	UKAS logo removal

Contents

Introduction

These updated Quality Standards for the care of people with stroke and transient ischaemic attack (TIA) are based on the Quality Standards which were used for peer review visits of stroke and TIA services in 2010/2011. The Quality Standards were revised in 2017 to take account of later guidance and to include rehabilitation of patients following a stroke and the Standards were circulated for comment within the West Midlands and comments received taken into account. The Standards were due for review in December 2020 but due to the Covid -19 pandemic, this suite of QS were revised to include any key changes and the date for a formal revision extended to June 2022.

We are grateful to Dr Indira Natarajan, Consultant Stroke Physician, Clinical Director Neurosciences, Department of Stroke Medicine, University Hospital of North Midlands NHS Trust and West Midlands Clinical Network Director for Stroke for all his help in reviewing these Standards.

Aims of the Quality Standards

The Quality Standards aim to improve the quality of services for people with stroke or transient ischaemic attack pathway and to help answer the question: "At each point on the pathway, how will I know that national guidance and best practice have been implemented?" The Quality Standards are suitable for use in self-assessment, monitoring by commissioners and providers, and peer review visits. They describe what services should be aiming to provide and providers and commissioners should be moving towards meeting all applicable Quality Standards within the next two to five years. The Quality Standards concentrate on the structure and process aspects of quality and should be seen alongside indicators of outcomes and the findings of the Sentinel Stroke National Audit Programme (SSNAP).

The Quality Standards are based on national guidance, in particular:

- NICE Quality Standard for Stroke (2016) and NICE Quality Pathways (updated 2020).
- Royal College of Physicians 'National Clinical Guideline for Stroke' (5th Edition) (2016).

Appendix 1 lists the references sources on which each of the Quality Standards is based. Appendix 2 cross-references each Standard to the British Standards Institution PAS 1616:2016 Healthcare – Provision of Clinical Services Specification and to the Care Quality Commission Key Lines of Enquiry. Appendix 3 gives a glossary of terms and abbreviations used in the Quality Standards.

Through use of the Quality Standards we hope that:

1. The local community, service users and carers will know more about the services they can expect.
2. Commissioners will be supported in assessing and meeting the needs of their population, improving health and reducing health inequalities, and will have better service specifications.
3. Service providers and commissioners will work together to improve service quality.
4. Service providers and commissioners will have external assurance of the quality of local services.
5. Reviewers will learn from taking part in review visits.
6. Good practice will be shared.
7. Service providers and commissioners will have better information to give to the Care Quality Commission, NHS England and NHS Improvement. The devolved nations may have different regulatory frameworks in place but these QS can still be used with these frameworks to provide additional assurance to commissioners of services..

Scope of the Quality Standards

These Quality Standards include the care of people with stroke or TIA. They are also appropriate for the initial stages of the care of people whose condition mimics stroke. These patients should be transferred without delay to a care pathway appropriate to their diagnosis; these care pathways are not covered by these Standards.

The Quality Standards do not cover:

a. Primary prevention of stroke and TIA;
b. Care of children and young people with stroke;
c. Details of endovascular and vascular surgery services for people with stroke, although links with these services are included;
d. Neuro-surgical management of patients with stroke, although links to neuro-surgical services are included;
e. Surgical and neurological management of sub-arachnoid haemorrhage;
f. Details of palliative and end of life care following a stroke.

The Quality Standards for the Services for People with Stroke or Transient Ischaemic Attack Pathway should sit within organisations' overall clinical governance arrangements. The QRS Clinical Governance Quality Standards describe the clinical governance arrangements which should be in place. Compliance in NHS provider organisations will usually be assured through regulatory bodies. Non-NHS organisations may wish to use the QRS Clinical Governance Quality Standards to assure themselves of the robustness of their overall clinical governance arrangements.

The Quality Standards for the care of people with stroke and TIA link with many other pathways and QRS

Standards, especially the following Quality Standards:

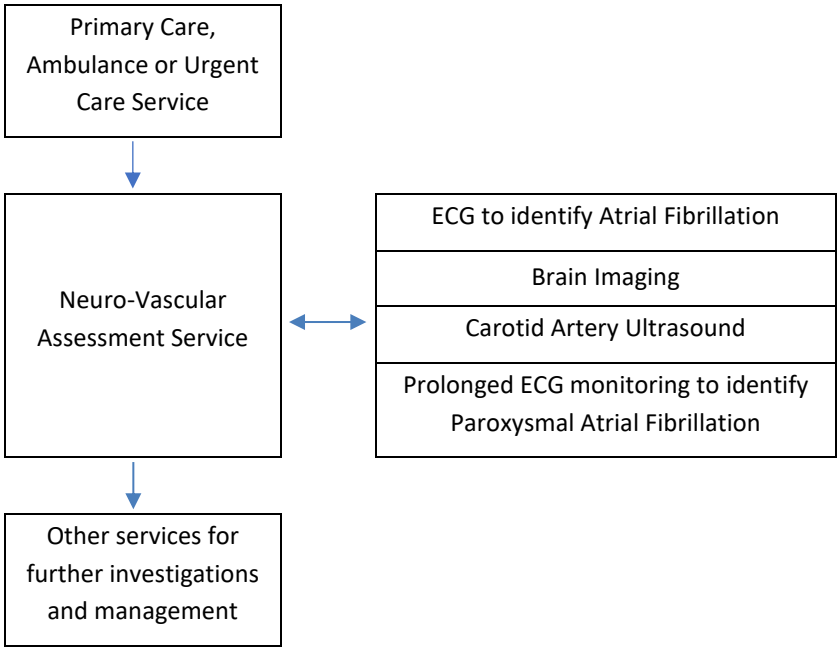
a. Urgent care
b. Vascular services
c. Care of people with long-term conditions, including sensory disabilities
d. Care of older people living with frailty
e. Transfer from acute hospital and intermediate care services

Latest versions of QRS Quality Standards are available on the QRS website www.qualityreviewservicewm.nhs.uk

Pathway

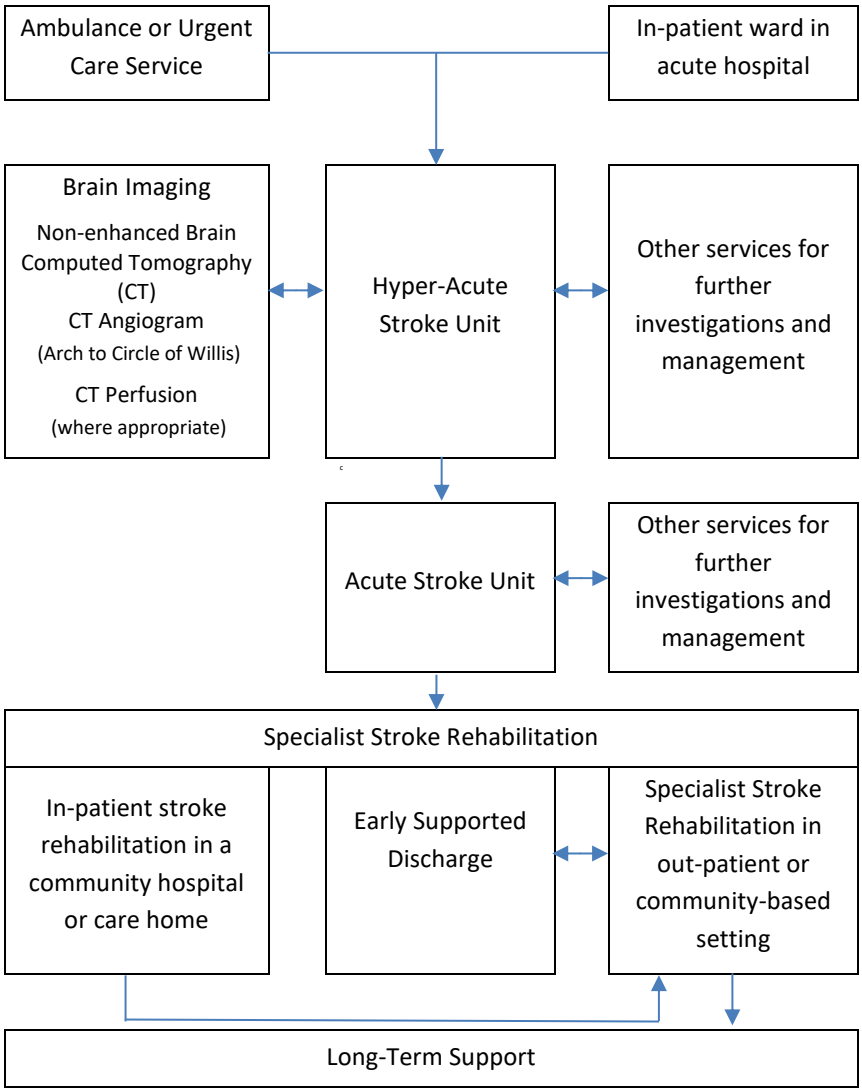
The Quality Standards follow the patient pathway for people with stroke or TIA and aim for the highest quality of care at each stage of the patient's journey:

Care of People with TIA:



The Neuro-vascular Assessment Service provides assessment and management of people with suspected TIA. The service may be provided in a neurovascular clinic or on an acute stroke unit. Patients may be referred by their general practitioner, by ambulance personnel or following presentation at an urgent care service.

Care of People with Stroke:



The following services are involved in the pathway of care for people with stroke:

Symptoms of stroke:

- Patients with suspected acute stroke should be admitted directly to a Hyper-Acute Stroke Unit and be assessed for emergency stroke treatments by a specialist physician without delay. This includes patients who are in-patients on other wards, with those on cardiology or renal wards and cardiothoracic units being at particularly high risk.

Hyper-Acute Stroke Unit:

- Hyper-Acute Stroke Units should provide assessment, diagnosis, emergency treatments and active management of physiological status and homeostasis on arrival at hospital and for up to 72 hours thereafter.

Acute Stroke Unit:

- Acute Stroke Units should provide acute in-patient care, early rehabilitation and prevention of complications for patients with stroke. Patients are normally transferred from a Hyper-Acute Stroke Unit to an Acute Stroke Unit within 72 hours of admission.
- Combined units may provide both hyper-acute and acute care and rehabilitation for people with stroke. All components of a specialist acute stroke unit should be based in a hospital which can investigate and manage patients with medical and neurological complications.

Specialist Stroke Rehabilitation Services:

Specialist Stroke Rehabilitation Services include:

a. Stroke rehabilitation provided in a non-acute in-patient setting, including a community hospital or care home
b. Specialist stroke Early Supported Discharge Team (ESD). Some Enhanced Early Supportive Discharge teams (EESD) may also be commissioned for those patients who have had a moderate to severe stroke.
c. Specialist stroke rehabilitation provided in an out-patient or community-based setting.

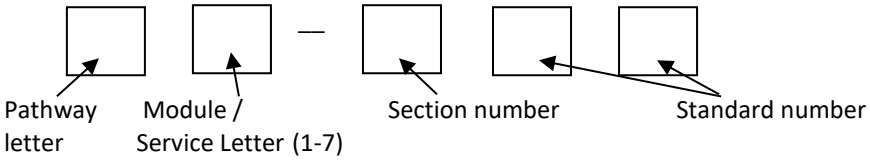
The pathway of care for people with stroke or TIA link with many other pathways and QRS Quality Standards, especially:

a. Urgent care
b. Care of people with long-term conditions, including sensory disabilities
c. Care of older people living with frailty
d. Transfer from acute hospital and intermediate care services

Structure of the Quality Standards

QRS Quality Standards Reference Structure

QRS Quality Standard reference numbers have the following structure:



Each Standard is structured as follows:

<table>
<tr><td>Reference Number (Ref)</td><td>This column contains the reference number for each Standard, which is unique to these Standards and is used for all cross-referencing. Each reference number is composed of two letters and three digits (see above and below for more detail).
The reference column also includes a guide to how the Standard will be reviewed:
<table>
<tr><td>BI</td><td>Background information</td></tr>
<tr><td>Visit</td><td>Visiting facilities</td></tr>
<tr><td>MP&S</td><td>Meeting service users (children, young people, adults) and staff</td></tr>
<tr><td>CNR</td><td>Case note review or clinical observation</td></tr>
<tr><td>Doc</td><td>Documentation should be available. Documentation may be written or be in the form of a website or other digital technologies.</td></tr>
</table>
The shaded area indicates the approach that will be used to reviewing the Quality Standard. APPENDIX 4 summarises the evidence needed for review visits.</td></tr>
<tr><td>Quality Standard (QS)</td><td>This describes the quality that services are expected to provide.</td></tr>
<tr><td>Notes</td><td>The notes give more detail about either the interpretation or the applicability of the Standard.</td></tr>
</table>

Pathway and Service Letters:

These generic Standards use the pathway letter C. The Standards are in the following sections:

CA-	Primary care	These Standards apply to General Practices, Walk-in Centres, Urgent Care Centres, Minor Injuries Units, or community services which care for patients at high risk of stroke or TIA, for example, community nursing services.
CB-	Ambulance Services	These Standards cover the assessment, immediate management and transfer of people with suspected stroke by ambulance services.
CE-	Acute Trust-wide	These Standards apply throughout acute hospitals, in particular, to Emergency Departments, Acute Medical Admissions Units and wards where patients are at higher risk of stroke, for example, cardiac, renal and cardiothoracic wards.
CN-	Stroke & TIA Services	These Standards apply to services whose prime function is to provide care for people with stroke or transient ischaemic attack. Standards for four different types of service are described: • **Neuro-Vascular Assessment Service (NVA)** • **Hyper-Acute Stroke Unit (HASU)** • **Acute Stroke Unit (ASU)** • **Specialist Stroke Rehabilitation Service (SR)** Definitions of each type of service are given above. Services may provide more than one type of care and will need to select the Standards applicable to the type of service provided.
CZ-	Commissioning	Commissioning Quality Standards are the responsibility of all health service commissioners, including specialist commissioners, working in partnership with social care commissioners for the commissioning of long-term support for people following stroke.

Topic Sections:

Each section covers the following topics:

-100	Information and Support for Patients and Carers
-200	Staffing
-300	Support Services
-400	Facilities and Equipment
-500	Guidelines and Protocols
-600	Service Organisation and Liaison with Other Services
-700	Governance

Within each section, each Standard has a unique two digit number. These are not always sequential, to ensure that similar standards in different pathways have the same two digit number.

The Quality Standards are cross-referenced to the British Standards Institution PAS16:16 and the Care Quality Commission Key Lines of enquiry in Appendix 2 .

Excel and PDF Versions

Using the Excel version of the Quality Standards has the following advantages:

- Standards applicable to different types of Service (XX-***) can be selected more easily by using the 'Filter' function and selecting the appropriate service in Columns B to F. [delete if not required]
- The spreadsheet includes a 'CQC' tab. This updates automatically when a self-assessment is completed and allows services to see, and demonstrate, the extent to which they are achieving the CQC Key Lines of Enquiry.

When using the Excel spreadsheet it is useful to know the following:

- If the tabs at the bottom of the spreadsheet do not appear, please minimise the spreadsheet and then maximise it again and the tabs should be there.
- 'Alt' and 'Enter' (together) allows you to put a new line within an Excel cell.

The PDF version includes appendices 1 to 5 which are not included in the Excel version.

Comments on the Quality Standards

The Quality Standards will be revised as new national guidance becomes available and as a result of experience of their use in peer review. Comments on the Quality Standards are welcomed and will be taken into account when they are updated. Comments should be sent to qrs@nhs.net

More information about QRS and its Quality Standards and reviews is available at www.qualityreviewservicewm.nhs.uk.

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Primary Care

Ref	Standard
CA-101 BI Visit MP&S CNR Doc	**Primary Care Information** Information should be offered to all patients referred for neuro-vascular assessment covering, at least: a. Brief description of the condition b. Arrangements for neuro-vascular assessment with clear indication of timescales c. What to do if symptoms recur d. Advice not to drive until the neuro-vascular assessment e. Sources of further advice and information
CA-299 BI Visit MP&S CNR Doc	**Primary Care Training** Staff working in primary care should have training in recognition of acute stroke and action that should be taken. *Notes:* *1. This information may be in the form of a website or on other digital technologies.*
CA-502 BI Visit MP&S CNR Doc	**Primary Care Suspected TIA Guidelines** Guidelines on the primary care management of patients with suspected TIA should be in use covering at least: a. Assessment of patients with suspected TIA, b. Immediate management, including indications for aspirin or alternative anti-platelet agent c. Indications for referral for neuro-vascular assessment within 24 hours of the onset of symptoms d. Referral information, including date and time of onset of symptoms, 12 lead ECG recording (if performed), and date and time when symptoms resolved e. Information to be given to patients and carers referred for neuro-vascular assessment (QS CA-101) f. Indications for admission g. Arrangements for referral to lifestyle management services h. Arrangements for six week follow up of well-being, cognitive impairment and impact on work. *Notes:* *1. Guidelines may also include advice on statins, blood pressure management and lifestyle management.* *2. Guidelines should cover the management of patients who present more than one week after the last symptom resolved who should be considered as low risk.*
CA-503 BI Visit MP&S CNR Doc	**Stroke & TIA Secondary Prevention Guidelines** Guidelines on secondary prevention of stroke and TIA should be in use covering: a. Smoking cessation b. Physical activity c. Nutrition d. Blood pressure management e. Lipid modification f. Anti-thrombolytic treatment g. Anticoagulation h. Management of other risk factors

Ref	Standard
CA-701 BI Visit MP&S CNR Doc	**Primary Care Stroke Governance** In general practices should: a. Audit regularly the primary and secondary prevention of stroke within their practice b. Maintain a register of patients with stroke or TIA.

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Ambulance Services

Ref	Standard
CB-201 BI Visit MP&S CNR Doc	**Staff training** All emergency ambulance crews should have training in: a. Recognition of symptoms of stroke b. Assessment of patients with suspected stroke using a validated tool e.g. FAST or ROSIER c. Immediate management of patients with suspected stroke
CB-501 BI Visit MP&S CNR Doc	**Care of patients with suspected stroke** Guidelines should be in use covering: a. Recognition and immediate management of patients with suspected stroke, including monitoring for arrythmias b. Screening for hypoglycaemia and for stroke using a validated tool e.g. FAST or ROSIER c. Transfer of all patients with suspected stroke to a Hyper-Acute Stroke Unit. d. Arrangements for pre-alerting the Hyper-Acute Stroke Unit *Notes:* *1. Guidelines should cover transfer of in-patients from other hospitals to hospitals with a HASU.* *2. Guidelines should be clear about the transfer of patients with conditions which mimic stroke.*
CB-502 BI Visit MP&S CNR Doc	**Care of Patients with Suspected TIA** Guidelines on the management of patients with suspected TIA should be in use covering: a. Assessment of patients with suspected TIA using a validated tool b. Immediate management, including indications for aspirin or alternative anti-platelet agent c. Indications for referral for neuro-vascular assessment within 24 hours. d. Referral information, including date and time of onset of symptoms, and date and time when symptoms resolved e. Information to be given to patients and carers referred for neuro-vascular assessment (QS CA-101) f. Indications for admission g. Arrangements for referral to lifestyle management services h. Arrangements for six week follow up of well-being, cognitive impairment and impact on work. *Notes:* *1. Ambulance staff should be able to make direct referrals for neuro-vascular assessment within agreed guidelines.*

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Acute Trust-wide

Ref	Standard
CC-201 BI Visit MP&S CNR Doc	**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. Assessment of patients with suspected stroke using ROSIER c. Immediate management of patients with suspected stroke, including transfer to a Hyper-Acute Stroke Unit *Notes:* *a. Transfer to a Hyper-Acute Stroke Unit may involve transfer to another hospital.*
CC-501 BI Visit MP&S CNR Doc	**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, including the assessment of the patient for their suitability for thrombolysis or thrombectomy 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 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. *Notes:* *1. This QS is numbered QS CE-501 for Emergency Departments, QS CF-501 in acute medical admissions and QS CC-501 in other wards and departments, especially cardiology and renal wards and cardiothoracic units.* *2. 'All patients with a suspected acute stroke should be admitted directly to a HASU and be assessed by a suitable stroke-skilled specialist within 1 hour and a stroke skilled consultant ASAP but within 14 hours upon arrival at hospital' (NHS Service, Seven days per week; The 4 Priority Clinical Standards applied to Stroke Services – Updated December 2018).* *3. Information for patients with suspected TIA should cover at least QS CA-101.*

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Stroke & TIA Services

Ref	Standard
CN-101 BI Visit MP&S CNR Doc	**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 *Notes:* *1. Information should be written in clear, plain English and should be available in formats and languages appropriate to the needs of the patients, including developmentally appropriate information for young people and people with learning disabilities. Information for young people should meet the 'Quality Criteria for Young People Friendly Health Services' (DH, 2011).* *2. Information may be in paper or electronic/e-learning formats or in the form of a website or other digital technologies. Guidance on how to access information is sufficient for compliance so long as this points to easily available information of appropriate quality. If the information is provided only in individual patient letters then examples will need to be seen by reviewers.* *3. This may be general Trust-wide (or equivalent) information. If so, services or clinics which are specific to one condition should be clearly identified. If the information is provided only in individual patient letters then examples of these will need to be available to reviewers.* *4. Information may be combined with condition-specific information (QS CN-102 & CN-103) and should be clear about information carers can receive with and without the patient's permission.*
CN-102 BI Visit MP&S CNR Doc	**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 *Notes:* *1. This information should be offered to patients with TIA attending as out-patients and to those receiving neuro-vascular assessment during in-patient care.* *2. As QS CN-101 notes 1 to 4.*

Ref	Standard
CN-103 BI Visit MP&S CNR Doc	**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 *Notes:* *1. SAs QS CN-101 notes 1 to 4.* *2. QS CZ-603 gives more detail of the long-term support for people with stroke and their carers which should be available.* *3. Sources of further advice and information should include national or local organisations providing support for people with stroke and their carers.*
CN-104 BI Visit MP&S CNR Doc	**Communication Aids** Communication aids should be available to enable patients to participate as fully as possible in decisions about their care.
CN-105 BI Visit MP&S CNR Doc	**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. *Notes:* *1. The management plan should include confirmation of follow-up arrangements.* *2. The copy of the management plan sent to the patient's GP should remind the GP of the need to include the patient on the practice stroke and TIA register*

Ref	Standard
CN-106 BI Visit MP&S CNR Doc	**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. *Notes:* *1. In-patients should have access to their care plan.*
CN-107 BI Visit MP&S CNR Doc	**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. *Notes:* *1. The Care Plan should be reviewed at least six months after discharge from hospital and at least annually thereafter. After discharge from specialist stroke service the review may be undertaken by primary care or by a Long-Term Support Service.*
CN-108 BI Visit MP&S CNR Doc	**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.
CN-196 BI Visit MP&S CNR Doc	**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 *Notes:* *1. QS CZ-603 gives more detail of the long-term support for people with stroke and their carers which should be available.*

Ref	Standard
CN-197 BI Visit MP&S CNR Doc	**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 *Notes:* *1. As QS CN-101 notes 1 to 4.* *2. This QS is about signposting to relevant services. The actual services available may be different in different areas.* *3. Availability of support services should be appropriate to the case mix and needs of patients and their carers.* ***4.** Information should explain patients' rights under the NHS Constitution.*
CN-198 BI Visit MP&S CNR Doc	**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 *Notes:* ***1.** Support for carers may include carer's breaks, emergency response, support for children in the family and cognitive and behavioural therapy, usually accessed through primary care-based psychological therapy services.*
CN-199 BI Visit MP&S CNR Doc	**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 *Notes:* *1. The arrangements for receiving feedback from patients and carers may involve surveys, including the national patient survey, patient stories, focus groups and /or other arrangements. They may involve Trust-wide arrangements so long as issues relating to the specific service can be identified.*
CN-201 BI Visit MP&S CNR Doc	**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. *Notes:* *1. Integrated health and social care services may be led by a registered social care professional.*

Ref	Standard
CN-202 BI Visit MP&S CNR Doc	**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. *Notes:* *1. The service should be available at some time during each day but may be organised differently on different days (especially at weekends). The guidance for patients, primary care, Emergency Departments and Acute Medical Admissions must be clear about these arrangements.* *2. The healthcare professional with competences in neurovascular assessment will normally be a doctor of level ST3 or above but other staffing models are feasible and may develop over time.* *3. The member or staff undertaking vascular ultrasound may be a vascular technologist, radiographer, nurse or radiologist.* *4. Additional staff may also be available, for example, a nurse, to offer support and information to patients.*
CN-203 BI Visit MP&S CNR Doc	**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. *Notes:* *1. This doctor should be training in the hyperacute and acute management of people with stroke, including the diagnostic and administrative procedures needed for the safe and timely delivery of emergency stroke treatments*
CN-204 BI Visit MP&S CNR Doc	**HASU: Consultant Availability** A consultant stroke specialist should be available to see patients within 14 hours of admission, and available for advice at other times. *Notes:* *1. The consultant should be able to attend the hospital within 30 minutes. Royal College of Physicians guidance (2016) is that a minimum of six consultants is needed to achieve this QS.* *2. Stroke skilled consultant is defined as a stroke consultant or a consultant that meets British Association of Stroke Physicians criteria. Only this can be accepted as first consultant review. Consultant level staff from nursing or therapy provided they have the appropriate skills can replace a medical consultant (NHS Services Seven Days a Week The 4 Priority Clinical Standards applied to Stroke Services, updated 2018).* *3. Where telemedicine is used for the assessment of people with suspected stroke, the consultant should be to discuss the case with the assessing clinician, talk to the patient and/or family/carers directly and review radiological investigations. Telemedicine should include a high-quality video link to enable the remote consultant to observe the clinical examination.*
CN-205 BI Visit MP&S CNR Doc	**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 seven days per week *Notes:* *1. Access to a consultant with expertise in stroke medicine may be achieved through telemedicine (see QS CN-204 note 2).*

Ref	Standard
CN-206 BI Visit MP&S CNR Doc	**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. *Notes:* 1. *A clear methodology should, ideally, be used to determine appropriate staffing levels and skill mix. Staff should have time allocated for their role in the service but roles may be part-time and staff may be shared with other services. 'National Clinical Guidelines for Stroke: 5th Edition' (RCP, 2016) gives guidance on appropriate staffing levels.* 2. *Any specialist nurses should have completed an appropriate post-registration (LBR) education programme.* 3. *Healthcare support workers should normally have, or be working towards, relevant NVQ level 2 or 3 qualifications. Skills for Health competence frameworks may be helpful in defining appropriate competences: www.skillsforhealth.org.uk* 4. *Reviewers should be concerned about the availability of staff with appropriate competences rather than management arrangements.* 5. *In acute settings, expected timescales for the patient pathway should be similar throughout the week, including weekends.*

Ref	Standard
CN-207 BI Visit MP&S CNR Doc	**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. *Notes:* 1. *This QS is about the needs of the service and cannot be met solely by individual staff appraisals and personal development reviews (PDRs). Appraisals and PDRs are sufficient for maintenance of competence. Details of individual appraisals and PDRs are not required. Reviewers may, however, request information about specific aspects of relevance to the service, in particular, where a therapeutic intervention or activity is undertaken rarely and/or where competence may not be maintained by the individual's usual clinical practice.* 2. *For compliance with this QS the service should provide:* **a.** *A matrix of the roles within the service, competences expected and approach to maintaining competences.* **b.** *A training and development plan showing how competences are being achieved and maintained.* 3. *Training may be delivered through a variety of mechanisms, including e-learning, Trust-wide training and departmental training. Resources such as the Stroke Training and Awareness Resources (STARS), Stroke Specific Education Framework (SSEF) may help to meet compliance with this QS.*
CN-208 BI Visit MP&S CNR Doc	**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 *Note: Competences for the management of acutely ill and deteriorating patients should also include competences in the use of the National Early Warning Score (NEWS) and Glasgow Coma Scale (GCS).*
CN-209 BI Visit MP&S CNR Doc	**Swallow screening** At least one healthcare professional on each shift should have competences in swallowing screening.
CN-210 BI Visit MP&S CNR Doc	**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.

Ref	Standard
CN-211 BI Visit MP&S CNR Doc	**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. *Notes:* *1. The responsibilities of the role may include other areas such as service planning and development, audit and governance.*
CN-298 BI Visit MP&S CNR Doc	**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
CN-299 BI Visit MP&S CNR Doc	**Administrative, Clerical and Data Collection Support** Administrative, clerical and data collection support should be available. *Notes:* *1. The amount of administrative, clerical and data collection support is not defined. Clinical staff should not, however, be spending unreasonable amounts of time which could be used for clinical work on administrative tasks.*
CN-301 BI Visit MP&S CNR Doc	**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. *Notes:* *1. Guidelines covering choice of imaging are covered by QS CP-502.*
CN-302 BI Visit MP&S CNR Doc	**Neurovascular Assessment –Equipment and Support Services** Access to the following equipment and services should be available on-site at all times: a. Ultrasound duplex devices b. Access to CT angiography when critical stenosis is identified

Ref	Standard
CN-303 BI Visit MP&S CNR Doc	**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 *Notes:* *1. Stroke-specific sequences include diffusion-weighted imaging and T2*.* *2. Guidelines covering choice of imaging are covered by QS CP-502.*
CN-304 BI Visit MP&S CNR Doc	**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
CN-305 BI Visit MP&S CNR Doc	**Critical Care** Level 3 critical care facilities should be available on the same hospital site.
CN-499 BI Visit MP&S CNR Doc	**IT Systems** IT systems should: a. Store, retrieve and transmit patient information for patient administration, clinical records and outcome information b. Provide mechanisms for the collection of other data to support service improvement, audit and revalidation c. If used to deliver online consultations, assessments and therapeutic interventions, meet audit and governance requirements. d. All clinical staff should be able, electronically and securely, to communicate person-identifiable data to other services involved in the patient's care. e. Business continuity plans should be in place covering potential IT systems failure, including arrangements for access to clients' records. *Note: IT and records systems should be easily accessible and integrated to ensure that all relevant information is readily available and avoid duplicate entry of data on individuals.*

Ref	Standard
CN-501 BI Visit MP&S CNR Doc	**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 *Notes:* *1. All referral guidelines should be agreed with the services to which patients are referred.* *2. Guidelines on prescribing must include initiation of treatment and should not just refer the patient back to their GP for a prescription.* *3. Guidelines should include immediate treatment, if indicated, and referral back to the GP for patients found not to have had a TIA but who have raised cardiovascular risk factors.* *4. Guidelines should be based on the latest evidence of effectiveness, including latest NICE / Royal College of Physicians guidance on neuro-vascular assessment and latest NICE /Royal College of Radiologists guidance on imaging of patients with suspected TIA.*
CN-502 BI Visit MP&S CNR Doc	**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 *Notes:* *1. All referral guidelines should be agreed with the services to which patients are referred.* *2. Guidelines should be based on the latest evidence of effectiveness, including latest NICE / Royal College of Physicians guidance on care of people with stroke and latest NICE /Royal College of Radiologists guidance on imaging of patients with suspected stroke.* *3. Guidelines should be explicit about the recognition and management of the particular physical, psychological and social needs of younger people with stroke, including liaison with regional neuro-rehabilitation services specialising in the care of younger adults.*

Ref	Standard
CN-503 BI Visit MP&S CNR Doc	**Thrombolysis and Thrombectomy 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 *Notes:* **1.** *This protocol should be based on latest evidence of effectiveness, including NICE guidance.*
CN-504 BI Visit MP&S CNR Doc	**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 *Notes:* *1. Guidelines should be based on the latest evidence of effectiveness, including latest NICE / Royal College of Physicians guidance on care of people with stroke.* *2. Guidelines should be explicit about the recognition and management of the particular physical, psychological and social needs of younger people with stroke, including liaison with regional neuro-rehabilitation services specialising in the care of younger adults.*
CN-505 BI Visit MP&S CNR Doc	**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
CN-506 BI Visit MP&S CNR Doc	**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.*

Ref	Standard
CN-507 BI Visit MP&S CNR Doc	**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. Optimal positioning g. Mobilisation h. Pain management i. 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 j. Screening for cognitive and mood changes within six weeks of onset of symptoms and six and 12 months thereafter k. Referral to lifestyle management services (dietician, smoking cessation, psychology)
CN-508 BI Visit MP&S CNR Doc	**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 *Notes:* **1.** *More detail of the required assessment measures is given in the Royal College of Physicians 'National Clinical Guideline for Stroke' (2016) sections 2.9.1 and 2.13.1.*
CN-509 BI Visit MP&S CNR Doc	**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

Ref	Standard
CN-510 BI Visit MP&S CNR Doc	**Driving** A protocol on driving advice should be in use, covering establishing the type of licence and giving appropriate advice on DVLA notification. *Notes:* **1.** *The protocol should comply with the latest version of 'Guidance to the current Medical Standards of Fitness to Drive' produced by the DVLA and reviewed every six months.*
CN-598 BI Visit MP&S CNR Doc	**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. Criteria and arrangements for Enhanced Early Supported Discharge (if commissioned) for in-patients with stroke and moderate to severe disability, with treatment at home beginning within 24 hours of discharge c. Discharge to a Stroke Unit closer to the patient's home (HASU only) d. Discharge to a stroke rehabilitation facility e. Discharge home with support from specialist stroke rehabilitation services f. 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 g. 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
CN-599 BI Visit MP&S CNR Doc	**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 *Notes:* **1.** *This is a linking QS and will not be reviewed in detail. Any lack of compliance seen during review visits will, however, be noted.*

Ref	Standard
CN-601 BI Visit MP&S CNR Doc	**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 thrombectomy/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 f. Arrangements for all patient referrals from primary care to be triaged by a stroke specialist and, if evidence of a Stroke or TIA, arrangements for the patient to be seen by the stroke service within 24hrs. g. Governance arrangements for providing consultations, assessments and therapeutic interventions, virtually, in the home or in informal locations *Notes:* *1. The treatment of patients with acute stroke should not be delayed until the multi-disciplinary team meeting.* *2. The Royal College of Physicians 'National Clinical Guideline for Stroke' (2016) section 2.5.1 recommends that "People with acute stroke who cannot be admitted to hospital should be seen by the specialist team at home or as an out-patient within 24 hours for diagnosis, treatment, rehabilitation and risk factor management at a standard comparable to that for in-patients". Achievement of this recommendation is desirable but has not been included in the QSs as it is not considered achievable within 2 to 5 years by all services.*
CN-602 BI Visit MP&S CNR Doc	**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. *Notes:* *1. The Early Supported Discharge multi-disciplinary team (MDT) meeting may be combined with other stroke services or may be separate, but representation should be the same as described in QS CN-601.* *2. This QS also applies to Enhanced Early Supported Discharge (EESD) services (if commissioned)* *3. All QSs applicable to a stroke rehabilitation service are also applicable to and should be met by the Early Supported Discharge Team.*
CN-701 BI Visit MP&S CNR Doc	**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

Ref	Standard
CN-702 BI Visit MP&S CNR Doc	**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 *Notes:* 1. *This QS may be achieved* through submission of data to the Sentinel Stroke National Audit Programme and Trust-wide collection of nursing care data ('k'). *2.* Six week follow-up should be available to patients discharged to care homes as well as to their own home. *3.* Screening for mood and cognitive changes should be undertaken using a validated tool.
CN-703 BI Visit MP&S CNR Doc	**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.
CN-704 BI Visit MP&S CNR Doc	**Research** The service should actively participate in stroke-related research.

Ref	Standard
CN-705 BI Visit MP&S CNR Doc	**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.
CN-706 BI Visit MP&S CNR Doc	**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. *Note: Network review and learning may be separate or form part of a wider programme of stroke education across the local Integrated Care System (ICS)*
CN-707 BI Visit MP&S CNR Doc	**Stroke Units: Network Review and Learning** The service should participate in the educational session run by the HASU from which patients are usually referred.
CN-798 BI Visit MP&S CNR Doc	**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
CN-799 BI Visit MP&S CNR Doc	**Document Control** All policies, procedures and guidelines should comply with Trust (or equivalent) document control procedures. *Notes:* ***1.*** *Specific documentary evidence of compliance is not required. This QS will be determined from the other documentary information provided. Copies of Trust Document control policies are not required.*

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Commissioning

Ref	Standard
CZ-101 BI Visit MP&S CNR Doc	**Public Awareness** Public awareness campaigns about the symptoms of stroke and action to take should be undertaken regularly, targeted at those most at risk, and formally evaluated. *Notes:* *1. Public awareness campaigns may be organised and delivered in partnership with other national and local organisations.*
CZ-299 BI Visit MP&S CNR Doc	**Primary Care Training** Commissioners should ensure that training in recognition of the symptoms of stroke and action to take is run regularly for staff working in: a. Primary care services b. Care homes *Notes:* **1.** *This QS links with QS CA- 299.*
CZ-601 BI Visit MP&S CNR Doc	**Needs Assessment and Strategy** Commissioners should have an agreed: a. Needs assessment b. Strategy for the development of services to meet local needs across the stroke and TIA patient pathway The local strategy should cover, when appropriate, prevention (primary and secondary), assessments, therapeutic interventions, rehabilitation and reablement. *Notes:* *1. The strategy should include metrics for monitoring the effectiveness of the strategy as a whole.*

Ref	Standard
CZ-602 BI Visit MP&S CNR Doc	**Commissioning: Pathway of Care** Services covering the pathway of care for people with stroke of all ages should be commissioned including: a. Neuro-vascular assessment b. Hyper-Acute Stroke Unit c. Stroke Unit d. Early supported discharge for patients with stroke e. Stroke Rehabilitation Services including: i. in-patient community rehabilitation ii. specialist community stroke rehabilitation *Notes:* **1.** *In-patient specialist stroke rehabilitation may be provided in a community hospital or care home.* **2.** *Different part of the pathway maybe commissioned from different organisations so long as the overall pathway provides consistent cohesive care for people with stroke.* **3.** *Early supported discharge and community rehabilitation should be available to residents of care homes as well as to people living in their own homes.* **4.** *Enhanced Early Supported Discharge Services (EESD) may also be commissioned to provide highly specialised intense rehabilitation for those patients who have had a moderate to severe stroke.* **5.** *Commissioners should have arrangements for liaising with NHS Specialised Commissioning for the development and implementation of services that are not commissioned locally.*
CZ-603 BI Visit MP&S CNR Doc	**Long-Term Support for People with Stroke** A long-term support service for people with stroke should be commissioned to provide: a. Follow-up six months after hospital discharge and annually thereafter b. Re-assessment of people with stroke who are no longer receiving rehabilitation, including by self-referral c. Referral for specialist assessment if required d. Advice on accessing housing, employment, social and leisure activities e. Maintenance interventions to enhance and maintain health and well- being f. Support for carers including: i. information, advice and training to help them care for a person with a stroke ii. access to assessments of their needs iii. psychological and emotional support and guidance *Notes:* *1. Follow-up provided by stroke rehabilitation services or by primary care should not be duplicated by long-term support services. These services should work together to ensure systematic, holistic long-term follow-up.* *2. Follow-up should be provided to people living in care homes as well as to those living in their own homes.* *3. Long-term support services may be commissioned by health and/or social care commissioners.* *4. Maintenance interventions include exercise programmes, peer support and a range of other community activities which promote social engagement and interaction.* *5. The long-term support service should link closely with palliative care services*

Ref	Standard
CZ-701 BI Visit MP&S CNR Doc	**Quality Monitoring** Commissioner should monitor key performance indicators and aggregate data on activity and outcomes from stroke and TIA services (CN-701 & CN-702) at least annually. *Notes:* 1. *Clinical Quality Review Meetings are sufficient for compliance with this QS only if there is evidence of discussion of the specific service.*

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APPENDIX 1 Reference Sources

Year	Publisher	Title	Number
2021	Healthcare Quality Improvement Partnership	Springboard for Progress: The Seventh SSNAP Annual Report Stroke care received for patients admitted to hospital between April 2019 to March 2020	47
2020	NHS England	Clinical guide for the management of remote consultations and remote working in secondary care during the coronavirus pandemic, Version 1: Publications approval reference: 001559 https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0044-Specialty-Guide-Virtual-Working-and-Coronavirus-27-March-20.pdf	45
2020	NHS England	Integrating Care: Next steps to building strong and effective integrated care systems across England	44
2019	Resuscitation Council (UK)	ReSPECT: Recommended Summary Plan for Emergency Care and Treatment. https://www.resus.org.uk/respect/	43
2019	Department of Health and Social Care	NHS Long Term Plan	42
2019	NHS England NHS West Midlands Clinical Networks	Stroke Care in the West Midlands: Clinical Review Visits for 7 Day Services.	41
2019	NHS England NHS West Midlands Clinical Networks	Stroke Care in the West Midlands: Early Supported Discharge & Rehabilitation	40
2019	National Institute for Health and Care Excellence	Social Care for older people with multiple long-term conditions	39
2019	National Institute of Health and Care Excellence	Stroke and transient ischaemic attack in over 16s: diagnosis and initial management, Nice guideline [ng128]. First published 2008, revised 2016 and 2019	2
2018	NHS England	NHS Services Seven Days a Week The 4 Priority Clinical Standards applied to Stroke Services	38
2018	Royal College of Radiologists	Acute stroke: CT reporting time in the Hyperacute Stroke Pathway	45
2018	The Royal College of Radiologists	Standards for the Reporting and Interpretation of Imaging Investigations, 2nd edition	46
2017	Royal College of Physicians	Rising to the Challenge: The Fourth SSNAP Annual Report. Stroke care received between April 2016 to March 2017	37
2017	NHS England	Next Steps on the Five Year Forward View	36
2016	Royal College of Physicians	National clinical guideline for stroke (5th edition)	6
2016	National Institute of Health and Care Excellence	Stroke in Adults NICE Quality Standard 2, (2010) updated 2016	3
2016	British Standards Institute	PAS 1616:2016 Healthcare - Provision of clinical services-specification	34

Year	Publisher	Title	Number
2015	Royal College of Physicians	Sentinel Stroke National Audit Programme (SSNAP)	21
2015	National Institute of Health and Care Excellence	Pathway: Stroke Rehabilitation http://pathways.nice.org.uk/pathways/stroke	22
2015	National Institute of Health and Care Excellence	Pathway: Stroke Overview http://pathways.nice.org.uk/pathways/stroke	23
2015	National Institute of Health and Care Excellence	Pathway: Acute Stroke http://pathways.nice.org.uk/pathways/stroke	24
2015	National Institute of Health and Care Excellence	Pathway: Specialist Care for People with Stroke http://pathways.nice.org.uk/pathways/stroke	25
2015	National Institute of Health and Care Excellence	Pathway: Carotid Imaging and carotid endarterectomise for people with TIA or non-disabling stroke http://pathways.nice.org.uk/pathways/stroke	26
2015	Care Quality Commission	How the CQC regulates: Appendices to the provider handbook	33
2015	National Institute of Health and Care Excellence	Pathway: Assessment and therapy in specific areas for people with stroke http://pathways.nice.org.uk/pathways/stroke	27
2015	ClinRisk	QRISK®2-2015 cardiovascular disease risk calculatorhttp://www.qrisk.org/index.php	28
2015	NHS England & Sandwell and West Birmingham CCG	Stroke Services: Configuration Decision Support Guide	32
2014	NHS England	Five Year Forward View	35
2014	Department of Health	Ambulance Quality Indicators – Clinical Outcomes for England	18
2014	NHS England	Forward view on Cardio-vascular Disease- list of high impact interventions https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/sop/red-prem-mort/cvd/#three-one	19
2014	NHS Scotland	Stroke Improvement Plan	20
2013	Department of Health	Cardiovascular Disease Outcomes Strategy, Improving outcomes for people with or at risk of cardiovascular disease	13
2013	National Institute of Health and Care Excellence	Stroke rehabilitation in adults, Clinical guideline 162	14
2013	National Institute of Health and Care Excellence	Apixaban for preventing stroke and systemic embolism in people with nonvalvular atrial fibrillation, Technology appraisal guidance [TA275]	15
2013	National Institute of Health and Care Excellence	Percutaneous closure of patent foramen ovale to prevent recurrent cerebral embolic events, Interventional procedure guidance [IPG472]	16

Year	Publisher	Title	Number
2013	National Institute of Health and Care Excellence	Transient ischaemic attack: clopidogrel, NICE advice [ESUOM23]	17
2013	NHS England	Putting Patients First: The NHS England Business Plan for 2013/4 - 2015/16	29
2013	NHS Litigation Authority	NHSLA Risk Management Standards for 2013/14 for NHS Trust Providing Acute, Community, or Mental Health and Learning Disability Services and Non-NHS providers of NHS Care	30
2012	NHS Midlands and East	Stroke Services Specification https://www.nottingham.ac.uk/emahsn/documents/stroke-hdocumentstrokespecificationeastmidlands.pdf	31
2012	Royal College of Physicians	Concise guide for stroke 2012	7
2012	National Institute of Health and Care Excellence	Alteplase for treating acute ischaemic stroke, Technology appraisal guidance [TA 264]	8
2012	National Institute of Health and Care Excellence	Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation, Technology appraisal guidance [TA256]	9
2012	Royal College of Physicians	Commissioning concise guide for stroke services	10
2012	National Institute of Health and Care Excellence	Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [CG138]	11
2012	NHS Improvement	Guidance on Risk Assessment and Stroke Prevention for Atrial Fibrillation (GRASP-AF) http://www.nhsiq.nhs.uk/media/2335846/grasp-af_2012_flyer.pdf	12
2011	The Neurohospitalist	Quality Measures in Stroke	4
2011	Care Quality Commission	Supporting life after stroke, A review of services for people who have had a stroke and their carers	5
2007	Department of Health	National Stroke Strategy	1

The table below shows the links between the Quality Standards and generic guidance documents. Quality Standards without a reference source are based on other QRS Quality Standards, taking into account comments received.

QS reference	Guidance documents	QS reference	Guidance documents	QS reference	Guidance documents
CA-101	6, 7, 19	CN-203	2, 3 6,24, 27, 31, 35, 36,41,47	CN-507	6, 14, 24, 25, 27,37,47
CA-299	6	CN-204	3, 6, 31, 35, 36,41,47	CN-508	6,47
CA-502	2, 6, 7, 12, 19, 28, 31 42	CN-205	2, 3 6, 23, 26, 28, 31, 38,41,47	CN-509	6, 14, 22, 23, 24, 31, 35, 36,37,47

QS reference	Guidance documents	QS reference	Guidance documents	QS reference	Guidance documents
CA-503	6,42	CN-206	2, 3, 6, 14, 23, 26, 28, 31, 35, 36,37,38,40 41,47	CN-510	6
CA-701	6	CN-207	3, 6, 31	CN-598	3, 5, 6, 11, 14, 31,37, 39,40
CB-201	6	CN-208	3, 6, 14,42,47	CN-599	6, 11, 14
CB-501	6,42	CN-209	3, 6 ,14, 24, 25, 26, 27, 37,47	CN-601	2,6, 7, 11, 14, 19, 20, 22, 23,24, 25, 26, 27, 35, 36,41,42,44,45,47
CB-502	6	CN-210	3, 6	CN-602	2,6,37,40
CC-201	6,42	CN-211	6	CN-701	6, 4, 10, 14, 21
CC-501	6, 7, 19, 20, 23, 24, 25, 26, 31,37,41,42	CN-298	6, 33, 34,43	CN-702	6, 4, 10, 14, 21, 31,37,40,41,42,47
CN-101	6,7,11, 31	CN-299	6	CN-703	6, 4, 10, 14, 21, 31,41,47
CN-102	2, 6	CN-301	3, 6, 7, 25,26, 31, 35 36,37,45,46	CN-704	6, 31
CN-103	6, 7, 31	CN-302	2, 6	CN-705	6
CN-104	6, 11, 28	CN-303	2,6, 31, 35, 36, 37,41	CN-706	6, 31,42,44
CN-105	2, 6, 7, 11	CN-304	2,3, 6, 7,37	CN-707	6, 31
CN-106	3, 6, 7, 11, 14, 20, 22, 23.24,27,31,37,39	CN-305	1,2	CN-798	6, 37,42
CN-107	3, 6, 7, 11, 14, 20, 22, 23.24,27,39	CN-499	6,35,36,38,39,42,44 45	CN-799	30
CN-108	3,6,7,39	CN-501	3,6,7, 23, 25, 26, 31,35,36,37,38,41,42, 45,46,47	CZ-101	6, 10, 11, 31,35
CN-196	3,6,11,1424,26,28,39	CN-502	3,6, 13, 14, 19, 20, 22, 23, 24, 25, 26, 27, 31,35,37,38,42,45,47	CZ-299	6
CN-197	6, 11	CN-503	3, 6, 23, 24, 25, 31,37,38,42	CZ-601	2 ,6, 10, 11, 32, 36, 44
CN-198	3, 6, 7,39	CN-504	3,6, 13, 14, 19, 20, 22, 23, 24, 25, 26, 27, 31, 35,37,47	CZ-602	2, 6, 7, 10, 14, 32, 35, 36,37,40,42,44
CN-199	6, 11,47	CN-505	3,6,16, 31,42	CZ-603	2,6,37,39,42
CN-201	6, 31	CN-506	6, 15, 31,37,42	CZ-701	6, 21, 32,37
CN-202	2, 3, 6,19, 20, 24, 26, 35,36,41				

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Appendix 2 Cross-References to British Standards Institution PAS16:16 and Care Quality Commission Key Lines of enquiry

The tables below show with an 'x' where a QRS Quality Standard addresses one of the following:

1. British Standards Institution PAS1616:2016 Healthcare – Provision of Clinical Services Specification

Ref	Requirements for the provision of clinical services
3	Leadership, strategy and management
4	Operational delivery of the clinical service
5	Systems to support clinical service delivery
6	Person-centred treatment and/or care
7	Risk and safety
8	Clinical effectiveness
9	Clinical service users with complex needs
10	Staffing a clinical service
11	Improvement, innovation and transformation
12	Educating the future workforce

2. Care Quality Commission's Key Lines of Enquiry (June 2017)

Ref	CQC Five Key Line of Enquiry
S	Are they safe?
E	Are they effective?
C	Are they caring?
R	Are they responsive?
W	Are they well-led?

Ref	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																											
		Safe						Effective						Caring			Responsive				Well-Led								
		S 1	S 2	S 3	S 4	S 5	S 6	E 1	E 2	E 3	E 4	E 5	E 6	C 1	C 2	C 3	R 1	R 2	R 3	R 4	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8
CA-101	6	x	x		x			x				x	x	x	x	x				x								
CA-299	4, 10, 12	x	x							x														x				
CA-502	6, 8, 9			x				x			x	x						x						x				
CA-503	6, 8, 9			x				x			x	x						x						x				
CA-701	3, 4, 7, 8, 11					x	x	x	x														x	x	x	x	x	x
CB-201	4, 10, 12	x	x							x														x				
CB-501	6, 8, 9			x				x			x	x						x						x				
CB-502	6, 8, 9			x				x			x	x						x						x				
CC-201	4, 10, 12	x	x							x																		
CC-501	6, 8, 9			x				x			x	x						x						x				
CN-101	6	x			x			x				x	x	x	x					x								
CN-102	6	x			x			x				x	x	x	x					x								
CN-103	6	x			x			x				x	x	x	x					x								
CN-104	6, 9												x	x	x													
CN-105	6		x	x				x			x	x	x	x	x		x	x										
CN-106	6		x	x				x			x	x	x	x	x		x	x										
CN-107	6		x	x				x			x	x	x	x	x		x	x										
CN-108	6														x													
CN-196	6			x	x			x			x				x			x										
CN-197	6	x						x							x		x			x								
CN-198	6							x				x			x		x											
CN-199	3, 7, 6	x					x								x				x								x	
CN-201	3, 4, 10, 12		x					x		x											x				x	x		
CN-202	3, 4, 10, 12		x					x		x											x				x	x		

Ref	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																									
		Safe						Effective						Caring			Responsive				Well-Led							
		S 1	S 2	S 3	S 4	S 5	S 6	E 1	E 2	E 3	E 4	E 5	E 6	C 1	C 2	C 3	R 1	R 2	R 3	R 4	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8
CN-203	3, 4, 10, 12		x					x		x											x				x	x		
CN-204	3, 4, 10, 12		x					x		x											x				x	x		
CN-205	3, 4, 10, 12		x					x		x											x				x	x		
CN-206	4, 10, 12		x					x		x											x	x	x		x	x		
CN-207	4, 10, 12		x					x		x											x	x	x		x	x		
CN-208	4, 10, 12		x					x		x											x	x	x		x	x		
CN-209	4, 10, 12		x					x		x											x	x	x		x	x		
CN-210	4, 10, 12		x					x		x											x	x	x		x	x		
CN-211	6			x				x			x							x						x				
CN-298	4, 10, 12		x					x		x												x	x		x	x		
CN-299	4, 10,12		x							x												x	x					
CN-301	4, 5, 6	x	x					x		x											x	x	x		x	x		
CN-302	4,5,6	x	x					x		x																		
CN-303	4, 5, 6, 8		x					x		x	x						x	x						x				
CN-304	4, 5, 6, 8		x					x		x	x						x	x						x				
CN-305	4							x																				
CN-499	5, 7	x		x				x								x			x									
CN-501	6, 8.2, 9		x					x				x	x	x	x													
CN-502	6, 8.2, 9		x					x				x	x	x	x													
CN-503	6, 8.2, 9		x					x				x	x	x	x													
CN-504	6, 8.2, 9		x	x				x				x	x	x	x													
CN-505	6, 8.2, 9		x					x				x	x	x	x													
CN-506	6, 8.2, 9		x					x				x	x	x	x													
CN-507	6, 8.2, 9		x					x				x	x	x	x													

Ref	British Standards Institute PAS 1616: 2016 3-12	CQC Five Key of Enquiry Questions																										
		Safe						Effective						Caring			Responsive				Well-Led							
		S 1	S 2	S 3	S 4	S 5	S 6	E 1	E 2	E 3	E 4	E 5	E 6	C 1	C 2	C 3	R 1	R 2	R 3	R 4	W 1	W 2	W 3	W 4	W 5	W 6	W 7	W 8
CN-508	6, 8.2, 9		x					x				x	x	x	x													
CN-509	6, 8.2, 9		x					x				x	x	x	x													
CN-510	6							x																				
CN-598	6,8.2, 9		x	x	x			x			x				x			x										
CN-599	6,8.2,9	x	x					x		x			x	x	x	x		x										
CN-601	6, 7, 8, 9, 10, 11, 12		x	x		x	x	x			x			x	x		x	x	x					x	x	x	x	x
CN-602	6							x										x						x				
CN-701	3.2, 4, 7, 8, 11					x	x	x	x													x		x	x	x	x	x
CN-702	3.2, 4, 7, 8, 11					x	x	x	x													x		x	x	x	x	x
CN-703	3.2, 4, 7, 8,11					x	x	x	x															x	x	x	x	x
CN-704	6,11								x																			x
CN-705	4, 10, 12	x	x							x														x				
CN-706	3.2, 4, 7, 8,11				x	x	x	x	x											x			x	x	x	x	x	x
CN-707	3.2, 4, 7, 8,11				x	x	x	x	x											x			x	x	x	x	x	x
CN-798	3.2, 4, 7, 8,11				x	x	x	x	x											x			x	x	x	x	x	x
CN-799	5			x																								
CZ-101	6							x				x			x													
CZ-299	4, 10, 12	x	x							x														x				
CZ-601	3,6,7,8,9,10,11			x	x			x			x	x					x	x	x			x		x				
CZ-602	3,6,7,8,9,10,11			x	x			x			x	x					x	x	x			x		x				
CZ-603	3,6,7,8,9,10,11			x	x			x			x	x					x	x	x			x		x				
CZ-701	3.2, 4, 7, 8,11					x	x	x	x															x	x	x	x	x

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APPENDIX 3 Glossary of Terms and Abbreviations

Glossary of terms and abbreviations	
Advocacy	Advocacy means to speak up for someone. It is about making things change because people's voices are heard and listened to. It is about making sure that people can make their own choices in life and have the chance to be as independent as they want to be.
ASU	Acute Stroke Unit providing acute in-patient care, early rehabilitation and prevention of complications for patients with stroke. Patients are normally transferred from a Hyper-Acute Stroke Unit to an Acute Stroke Unit within 72 hours of admission.
BI	Background information to review team.
Carer	Throughout the Quality Standards the term 'carer' applies to both family carers and paid carers or support workers.
CCG	Clinical Commissioning Group.
Commissioner	A commissioner decides how NHS and / or social care resources are spent, with the aim of improving health, reducing inequalities, and enhancing patient experience.
CNR	Case note review or clinical observation.
CQC	The Care Quality Commission is the independent regulator of health and social care in England.
CT scan	Computerised Tomography scan
CTA	Computed Tomography Angiography
DH	Department of Health.
Doc	Documentation should be available. Documentation may be in the form of a website or other digital technologies.
DVLA	Driver and Vehicle Licensing Agency
ECG	Electrocardiogram
FAST	Face Arm Speech Test
GP	A GP is a medical doctor, sometimes called a family doctor. They are usually the first person patients see for their health care, and they help patients to access other services.
HealthWatch	The 'consumer champion' for both health and adult social care and should be the independent, influential and effective local voice of the public on health issues.
HASU	Hyper-Acute Stroke Unit providing assessment, diagnosis, emergency treatments and active management of physiological status and homeostasis on arrival at hospital and for up to 72 hours thereafter.
LBR	Learning beyond registration.
MP&S	Meeting patients / service users, carers and staff.
MRA	Magnetic resonance angiography
MRI	Magnetic resonance imaging
NICE	National Institute for Health and Care Excellence.
NHSLA	NHS Litigation Authority.
NVQ	National Vocational Qualification.
NVA	Neuro-Vascular Assessment Service for the assessment and management of people with suspected TIA.

Glossary of terms and abbreviations	
PDR	Performance Development Review.
Provider	A health or social care organisation which provides services to patients.
QS	Quality Standard.
QRS	Quality Review Service
ROSIER	The Recognition of Stroke in the Emergency Room scale. An assessment tool used as part of initial assessment of patients.
Service provider	See 'Provider'.
Service commissioner	See 'Commissioner'.
Specialist	A healthcare professional with the necessary knowledge and skills in managing the care of people with stroke and conditions that mimic stroke, usually by having a relevant further qualification and keeping up to date through continuing professional development. This does not require the healthcare professional exclusively to manage the care of people with stroke, but does require them to have specific knowledge and practical experience of stroke.
SR	Stroke Rehabilitation Service. This includes: a. Stroke rehabilitation provided in a non-acute in-patient setting, including a community hospital or care home b. Specialist stroke Early Supported Discharge Team c. Specialist stroke rehabilitation service provided in an out-patient or community-based setting.
TIA	Transient Ischaemic Attack
Trust	A NHS Trust, NHS Foundation Trust or other organisation with management responsibility for the service.

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APPENDIX 4 Presentation of Evidence for Peer Review Visits

Each Quality Standard reference column includes a box which illustrates how compliance will be reviewed.

Quality Standard reference column	
Background information	This means that the information should be included in the background report or self-assessment.
Visiting facilities	Reviewers will look for the information while they are visiting the service.
Meeting patients, carers and staff	These Standards will be discussed with patient, carers and /or staff as appropriate.
Case note review or clinical observation	A few Quality Standards require reviewers to look at case notes or other clinical information.
Documentation	These are policies, guidelines and other documentation that reviewers will need to see. Documentation may be in the form of a website or other digital technologies.

The following table summarises the evidence needed for each Quality Standard.

QS Ref. No	QS Short Title	Background report BI	Visit Visit	Meeting patients & staff MP&S	Case note review or clinical observation CNR	Documentation needed DOC	Illustration of Documentation Required
CA-101	Primary Care Information			X			
CA-299	Primary Care Training			X		X	Examples of training for primary care
CA-502	Primary Care Suspected TIA Guidelines			X		X	**Guidelines:** Covering the primary care management of patients with suspected TIA
CA-503	Stroke & TIA Secondary Prevention Guidelines			X		X	**Guidelines:** Covering secondary prevention of stroke and TIA
CA-701	Primary Care Stroke Governance			X		X	Examples of audits and register of patients with stroke and TIA
CB-201	Staff training			X		X	Examples of training for ambulance crews
CB-501	Care of patients with suspected stroke			X		X	**Guidelines:** Covering the management of patients with suspected stroke
CB-502	Care of Patients with Suspected TIA			X		X	**Guidelines:** Covering the management of patients with suspected TIA
CC-201	Staff training			X		X	Examples of training for emergency department staff

QS Ref. No	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	DOC	
CC-501	Stroke and TIA Guidelines			X	X	X	**Guidelines:** Covering the assessment and management of patients with suspected stroke or TIA
CN-101	Service Information		X	X		X	Patient information about the service
CN-102	TIA Patient Information		X	X		X	Patient information about the service
CN-103	Stroke Patient Information		X	X		X	Patient information about the service
CN-104	Communication Aids		X	X			
CN-105	TIA Management Plan			X	X		
CN-106	Stroke Care Plan			X	X		
CN-107	Review of Care Plan			X	X		
CN-108	Training for Carers			X			
CN-196	Discharge Plan			X	X		
CN-197	General Support for Patients and Carers		X	X			
CN-198	Carers' Needs			X			
CN-199	Involving Patients and Carers			X		X	Examples of changes made as a result of feedback
CN-201	Lead Clinician/s	X					
CN-202	NVA: Staffing	X		X		X	Examples of staff rotas and competences for performing vascular ultrasound
CN-203	HASU: Senior Medical Staffing	X					
CN-204	HASU: Consultant Availability	X		X			
CN-205	Acute Stroke Units: Consultant Availability	X		X			
CN-206	Staffing Levels and Skill Mix			X		X	Examples of staff rotas showing sufficient staff with competences for caring for people with stroke and stroke rehabilitation

QS Ref. No	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	DOC	
CN-207	Service Competences and Training Plan			X		X	Competence Framework and Training Plan: •Competence framework describing the competences expected for roles within the service. •Training and development plan to show how staff will achieve and maintain competences
CN-208	In-patient Stroke Services: Nurse Staffing			X		X	Examples of staff rotas showing sufficient staff with competences for caring for people with stroke and stroke rehabilitation
CN-209	Swallow screening			X		X	Examples of staff rotas showing sufficient staff with competences swallow screening
CN-210	Management of acutely ill and deteriorating patients			X		X	Examples of staff rotas. Competences may be part of CN-2017
CN-211	Coordinator	X		X			
CN-298	Competences – All Health and Social Care Professionals	X		X			
CN-299	Administrative, Clerical and Data Collection Support	X		X			
CN-301	CT Scanning for Patients with Stroke	X		X			
CN-302	Neuro-Vascular - Equipment and Support Services		X				
CN-303	Hyper-Acute and Acute Stroke - Support Services	X		X			
CN-304	Other Support Services	X		X			
CN-305	Critical Care		X				
CN-499	IT System		X	X			
CN-501	Neuro-Vascular Assessment Guidelines			X	X	X	**Guidelines:** Neuro-vascular assessment

QS Ref. No	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	DOC	
CN-502	Clinical Guidelines: Hyper-Acute Stroke Care			X	X	X	**Clinical Guidelines:** Hyper-Acute Stroke Care
CN-503	Thrombolysis and Thrombectomy Protocol			X	X	X	**Protocol:** Thrombolysis and Thrombectomy
CN-504	Clinical Guidelines - Hyper-Acute and Acute Stroke Care			X	X	X	**Clinical Guidelines:** Management of Hyper-Acute and Acute Stroke Care
CN-505	Clinical Guidelines: Other Conditions			X	X	X	**Clinical Guidelines:** Other Conditions as defined by the QS
CN-506	Clinical Guidelines: Underlying Conditions			X	X	X	**Clinical Guidelines:** Conditions as defined by the QS
CN-507	Clinical Guidelines: All Stroke Services			X	X	X	**Clinical Guidelines:** All Stroke Services as defined by the QS
CN-508	Rehabilitation Assessment			X	X	X	**Clinical Guidelines:** Rehabilitation assessment
CN-509	Rehabilitation Guidelines			X	X	X	**Clinical Guidelines:** Rehabilitation
CN-510	Driving			X	X	X	**Clinical Guidelines:**
CN-598	Discharge Planning Guidelines			X	X	X	**Guidelines:** Discharge guidelines
CN-599	Care of Vulnerable People			X			**Guidelines:** for the care of vulnerable adults. These may be Trust-wide guidelines
CN-601	Operational Policy			X		X	**Policy:** Operational Policy
CN-602	Early Supported Discharge Team MDT Meeting			X		X	Documentation depends on local arrangements, for example, minutes of MDT meetings held within the service
CN-701	TIA Data Collection			X		X	Examples of data showing compliance with the QS
CN-702	Stroke Data Collection			X		X	Audit programme or plan Examples of completed audits, action plans and monitoring
CN-703	National Audit Programme	X				X	Example of most recent Sentinel Stroke National Audit Programme data
CN-704	Research			X		X	Examples of participation in research

QS Ref. No	QS Short Title	Background report	Visit	Meeting patients & staff	Case note review or clinical observation	Documentation needed	Illustration of Documentation Required
		BI	Visit	MP&S	CNR	DOC	
CN-705	Primary Care Education			X		X	Examples of educational sessions provided.
CN-706	HASU: Network Review and Learning			X		X	Documentation depends on local arrangements, for example, minutes of review and learning meetings held within the HASU service
CN-707	Stroke Units: Network Review and Learning			X		X	Documentation depends on local arrangements, for example, minutes of review and learning meetings for linked stroke units coordinated by the HASU
CN-798	Multi-disciplinary Review and Learning			X		X	Documentation depends on local arrangements, for example, minutes of review and learning meetings held within the service
CN-799	Document Control					X	Compliance determined from other documentation presented
CZ-101	Public Awareness			X		X	Examples of public awareness campaigns
CZ-299	Primary Care Training			X		X	Primary care education programme
CZ-601	Needs Assessment and Strategy			X		X	Local needs assessment and strategy for stroke and TIA
CZ-602	Commissioning: Pathway of Care			X		X	Service Specifications
CZ-603	Long-Term Support for People with Stroke			X		X	Service Specifications
CZ-701	Quality Monitoring			X		X	Documentation depends on local arrangements, for example, minutes of review and learning meetings involving all local services

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