Integrated Practice of the Stroke Nursing Team

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Overview

- Overview of the role of the Stroke Nurse Practitioner
- Overview of the Stroke Nurse Specialist role in the TIA & vascular service
- The role of the Stroke Research Nurse
- Examples of integration within the stroke team
A Brief History of the Stroke Nurse Practitioner...
(from back door to front door.)

- Pre 1998 no acute unit, only 28 rehab beds, very ad hoc patient referral. When Acute unit opened only 5 to 20% of Acute CVA’s were admitted.

- SNS role set up in 2000 as a secondment. Looking at acute pathway, inconsistent management of stroke patients, and early discharge to CRT.

- Funded by PCT’s.

- No office.

- 1 nurse.
Stroke Nurse Practitioner

- As acute services developed, the role developed to 5 nurses across two sites (NGH 4, RHH1) employed by Acute and Elderly Medicine

- All patients admitted were seen, assessed, and triaged to the stroke units.

- Stroke nurses attended ward rounds on stroke units.

- Assisted with discharge planning to community services

- Pre HASU started inputting into ED to assess earlier.
Stroke Nurse Practitioner Role today

- Sheffield Stroke Service centralised in 2010 to the non ED site.

- HASU created.

- SNS role became Stroke Nurse Practitioner, HASU based and admissions based.
Current role

- Taking direct paramedic referrals & triaging.
- Consideration of straight to scan, ward, ED
- Receive patient from paramedics/see on arrival.
- Initial history taking.
- NIHSS
- Imaging requesting.
- Working with NAU staff to ensure bloods, ECG, observations are performed
Current role

• Ensuring care protocols are followed e.g. flowtron therapy, blood pressure management.

• HASU based SNP’s continue close monitoring of patients in the hyper acute stage, and see and assess new admissions through the night.

• SSNAP – involved to some extent in all 10 domains of SSNAP. Mainly scanning, stroke unit, Thrombolysis, Specialist Assessment, standards by discharge, and discharge process.
More recent developments

- Straight to scan for thrombolysis candidates.
- Thrombolysis immediately after CT in radiology whilst considering Thrombectomy.
- Straight to scan for patients on anticoagulants to aid rapid diagnosis and management of possible haemorrhagic strokes.
- Non Medical Prescribing.
- APACS.
Role of the Stroke Nurse Specialist

TIA clinics
- Development of the service
- Planning and organizing daily service
- Delivering the service

Vascular intervention
- Co-ordination of referrals made to vascular services at NGH
Current practices

TIA / minor stroke clinic

Pre clinic

- Point of contact for advice regarding referrals
- Screen and triage received referrals
- Obtain further information from referrer as needed
- Obtain medical opinion and decision on identified probable inappropriate referrals
- Ensure patients offered an appointment within guideline time frames
Current practices

- Book appropriate imaging for each patient
- Request necessary blood tests

Clinic

- Obtain clinical history of event
- Identify lifestyle and medical risk factors
- Obtain blood samples
- Obtain ECG and BP measurements
Current practices

- Review imaging
- Discuss TIA/Stroke presentation
- Discuss risk factor modification
- Advise regarding driving regulations
- Provide advice leaflets as appropriate
- Request medical review as necessary
Current practices

- Identify and discuss potential research studies that may be eligible to participate in.
Current practices

Post clinic

- Review investigation reports
- Discuss with Stroke Consultant as necessary
- Collate clinic information and results of investigations
- Produce clinic outcome for return to patients GP
- Arrange follow up as required
- Refer to CST as required
Current practices

Vascular intervention

- Point of contact at RHH site for referrals made to Vascular services at NGH for carotid intervention
- Ensure referral forms available
- Monitor the performance of carotid MRA’s on inpatients and outpatients within RHH site
- Check MRA reports
Current practices

- Establish if referral made if appropriate or reason for not referring
- Point of contact for return of referrals with management plan
- Liaise with co-ordinator at NGH for weekly Vascular MDT meeting
- Ensure notes available for patients to be discussed at MDT meeting
Current practices

- Attend MDT
- Feedback outcome to referrer and patient.
- Feedback to research team regarding potential trial patients
- Ensure MDT outcome forms filed in patients notes
- Maintain electronic record of MDT lists and outcome forms
Future and Current developments

- Development of the TIA service in line with the RCP Stroke Guidelines
- Development of Vascular Intervention services to meet requirements of RCP Stroke Guidelines
Role of the Stroke Research Nurse

- Directorate based
- Screen
- Recruit
- Follow up
- Data Queries
- Set up trials/ close trials
- Raise awareness
Stroke Research in Sheffield

- Part of the Yorkshire and Humber Local Research Network
- Highest recruiting Trust in the country out of 168 Trusts
- 14 trials open to recruitment
- 3 in Set up
- 8 closing down
• To determine whether systemic cooling, improves functional outcome at 3 months in patients with acute ischaemic stroke.

• Target body temperature between 34.0 and 35.0°C, started within 6 hours of symptom onset and maintained for 12 hours

• The cooling period is expected not to exceed 24 hours (2 h reaching target temperature, 12 h of maintaining a core body temperature of between 34.0°C and 35.0°C and a re-warming period of up to 10 h).
Surface cooling
A randomised controlled trial of Tranexamic acid for Intracerebral Haemorrhage

Primary objective: To test effectiveness of tranexamic acid on death and dependency in ICH

Secondary objectives: To test the effects of tranexamic acid on safety, haematoma expansion, discharge disposition, cognition, mood, quality of life, cost effectiveness

Double Blinded trial
RIGHT-2

- Rapid Intervention with GTN in Hypertensive stroke Trial-2
- Managed in 30 hospital sites around the country
- Intervention - Transdermal GTN 5 mg patch in ambulance
- Comparator - ‘Sham’ patch
Inclusion Criteria

- Patients presenting to paramedics in context of 999 ambulance call for ‘stroke’
- Ages 18 years or more
- ‘Face/Arm/Speech’ Time (FAST) score ≥2
- Time ≤4 hours of onset
- Systolic BP ≥120 mmHg
- Paramedic:
  - Is trained in RIGHT-2 procedures
  - Will take patient to a participating comprehensive/primary stroke centre
- Written or witnessed oral consent, or relative/paramedic proxy assent
Exclusion Criteria

- Patient at a Nursing Home
- Glucose (BM stix) <2.5 mmol/l
- Glasgow Coma Scale <8
- Witnessed seizure/fit at presentation
- Known life expectancy <6 months
- Known to have taken a PDE5 inhibitor, e.g. sildenafil, in previous day before stroke
- Known sensitivity to Transiderm Nitro patch
- Known sensitivity to Duoderm hydrocolloid dressing
Future Goals

- Hyper acute stroke research centre bid
- Integrating research in to practice, ANP role
- More holistic and streamline care for the patient and/or their relatives
- Developing joint clinical and research roles
- More time efficient
- Cost effective
Example of integration

- Direct to scan, attended by Stroke Team
- CT scan - patient had ICH
- Stroke Nurse Practitioner informed Stroke Research Sister
- Patient was less than 1 hour of symptom onset and fulfilled inclusion criteria for TICH-2
- SNP and SRS worked with HASU consultant to consent and recruit patient into TICH-2
- Patient commenced treatment within 1 hour of symptom onset
- Trial still open and recruiting/ no results yet
Questions?