Stroke Study Day

An update on the new National Clinical Guidelines, new practices, developments, research and hyper acute care
**Hyper acute stroke care**
- 9.45 Hyper-acute stroke assessment- Dr Ali Ali
- 10.35 A review of the inclusion and exclusion criteria for IV thrombolysis in AIS- Dr Gary Pratt
- 11.30 Coffee
- 11.45 Mechanical thrombectomy for AIS- Prof Arshad Majid
- 12.20 Role of modern imaging in assessment of AIS- Dr Richard Dyde
- 13.00 Lunch
- 13.30 BP Management in acute stroke- Dr Kirsty Harkness
- 14.15 The use of NOACs in stroke- Dr. Muhammad Khan
- 15.00 Presentations and discussions on Interesting/challenging cases/ Stroke team
- 16.00 Panel questions and close

**The stroke pathway**
- 9.45- STARS- Stroke and TIA Awareness and response to symptoms study Dr Jess Redgrave
- 10.30- Integrated Practice of the Stroke Nursing Team
- Geoff Dunn, Emma Richards and Clare Doyle
- 11.30 Coffee
- 11.45 New developments in psychological therapy for stroke survivors and carers: Living better with stroke- Developing psychological flexibility- Drs. Jane Barton, Liz Roberts, Jo Hawker and Fiona Goudie
- 12.25 Extended Occupational Therapy Role and Psychological Wellbeing Practitioner- Julie Bradbury
- 13.00 Lunch
- 13.30 National Stroke Nursing Forum and stroke education update- Amanda Jones
- 13.45 "What's my goal - the use of an updated toolkit”- Emma Gibbs and Fiona Levitt
- 14.15 "Development of the MCAST: a toolkit to support mental capacity assessment". - Mark Jayes
- 14. 45- What are the Experiences of Stroke Survivors with Managing Eating? (ESSME Study)- Natalie Jones
- 15.30-Life After Stroke Centre- Julia MacLeod/Sue Charlesworth
- 16.00 Questions/comments and close.
The extent of stroke

- Stroke is the 4th single leading cause of death in the UK
- Leading cause of disability
- Kills more women than breast cancer
- 152,000 people suffer a stroke in the UK each year (a stroke is happening every 3 minutes 27 seconds to someone)
- 1/8 people who have a stroke will die within the first month
The extent of stroke

- Age is the single most important risk factor for stroke \(^{(1)}\).
- People aged between 65 and over increased by 4 million between 1952-2002 \(^{(2)}\)
- Number of people 65+ expected to rise by approx 50% in the next 17 years to over 16 million. \(^{(3)}\)
- £9billion is spent on stroke by the NHS and wider economy each year \(^{(1)}\)

*A huge issue and likely to get bigger with the rise in the ageing population*
National Guidance
The key National Drivers for stroke

- National Stroke Strategy- DoH December 2007- 2017 (10 year strategy)
- Diagnosis and initial management of Acute Stroke and TIA- NICE, July 2008
- NICE stroke rehabilitation guidelines- Long-term rehabilitation after stroke, DoH 2013 (currently being reviewed)
- SSNAP- Sentinel Stroke National Audit Programme- mandatory from January 2013
RCP National Clinical Guidelines for Stroke-2016- What’s New?- Some key highlights

Guideline changes are only made when there have been new robust evidence that will improve patient outcomes

Amanda Jones
Clinical Lead for Stroke,
Sheffield Teaching Hospitals,
member of the national RCP stroke guidelines working party group
RCP National Clinical Guideline for Stroke, RCP 2016

• Working party is made up of experienced clinicians working in stroke, chaired by the National Clinical Director of Stroke, Professor Tony Rudd

• Work with colleagues to appraise all the new evidence and produce evidence based guidelines to direct clinical care, which is audited- SSNAP

• Published every 4 years since 2000

• Cover the whole of the stroke pathway

• Include profession specific guidelines, which highlight key discipline specific guidance (these are just lifted out of the main guidelines)

• Guidelines will be formally launched at UK Stroke Forum November 2016
RCP National Clinical Guideline for Stroke, RCP 2016

• Available on line from Monday 3rd October
• Free to access, there is no paper copy, but can print it off
• Full guideline, concise profession specific guidelines, appendices including tables of evidence, patient version (down loadable-very good resource), commissioners guide
• Formal launch at the UK Stroke Forum in Liverpool 28th-30th November
• There will be a press release
National update- great strides have been made but still many challenges

• No longer a national priority which is a concern
• 40% of trusts have stroke consultant vacancies, and real issue with training posts
• Concerns about low levels of nurses in stroke- many services carrying significant vacancies
• SALT levels remain low
• P/T and O/T better than SALT, but national shortages
• Psychology access remains challenging
• National drive for HAS centres- Northumbria model interesting- have built a new hyper-acute hospital, which has a HASU in it- positive and more sustainable and better access to other hyper acute services- Prof Helen Rogers- a good contact
National update

• New CEO at the Stroke Association- Juliet Bouverie (cancer background) pushing for a new National Stroke Strategy to get stroke back on national agenda- a new National Audit Office enquiry (the last one kick started the National Stroke Strategy)

• A new NHS England working group, looking at a NHS wide action plan for stroke – good to raise the profile
Main national actions

• True 7 day working
• Contact with a consultant within 14 hours
• Daily consultant wards rounds (appropriate)
• HAS centres- currently, 124 HASUs in England, need to reduce to 90 for sustainability and improved patient outcomes
Guidelines- Overall organisation of acute stroke services

• Effective stroke care will only occur if the organisational structure facilitates the delivery of the best treatments at the optimal time.

• Intravenous thrombolysis (a recommended treatment) can only be given within 4.5 hours of stroke onset if people arrive in the appropriate setting within that time.

• Major urban reorganisations of stroke services have taken place in some parts of the UK to improve access to hyper-acute stroke unit care. Recent evidence from Manchester and London suggests that such care should be available in 24/7 hyper-acute stroke centres and should be for all people with acute stroke, not just those who might be suitable for intravenous thrombolysis.
Organisation of care

• 2012 - Patients with suspected stroke should be transferred urgently to a HASU- Hyper Acute Stroke Unit

• 2016 - Transferred urgently to a HASC- Hyper Acute Stroke Centre

• To a HASU on site or a neighbouring hospital with a HASU- Regionally in our area- Working Together Programme- working towards 2 HASU’s in South Yorkshire; Sheffield and Doncaster

• HASU care for up to 72 hours

• Stroke mimics should be transferred from the stroke unit without delay, to appropriate pathway (mimics haven’t been mentioned previously)
Stroke Clinicians

A specialist

• A healthcare professional with the necessary knowledge and skills in managing 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 people with stroke, but does require them to have specific knowledge and practical experience of stroke.

A specialist team

• A group of specialists who work together regularly managing people with stroke and conditions that mimic stroke, and who between them have the knowledge and skills to assess and resolve the majority of problems.
• At a minimum, any specialist unit, team or service must be able to deliver all the relevant recommendations made in this guideline. This does not require the team exclusively to manage people with stroke, but the team should have specific knowledge and practical experience of stroke.
<table>
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<tr>
<th></th>
<th>PT (WTE/5 beds)</th>
<th>OT (WTE/5 beds)</th>
<th>SALT (WTE/5 beds)</th>
<th>Clinical Neuro-psychologist / clinical psychologist (WTE/5 beds)</th>
<th>Dietitian (WTE/5 beds)</th>
<th>Nurse (WTE/bed)</th>
<th>Consultant Stroke Physician</th>
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<tbody>
<tr>
<td><strong>Hyper-acute Stroke Unit</strong></td>
<td>0.73</td>
<td>0.68</td>
<td>0.34</td>
<td>0.20</td>
<td>0.15</td>
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<td>24/7 availability; minimum 6 thrombolysis trained physicians on rota, consultant review 7 days per week</td>
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<tr>
<td><strong>Acute Stroke Unit</strong></td>
<td>0.84</td>
<td>0.81</td>
<td>0.40</td>
<td>0.20</td>
<td>0.15</td>
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<td>Consultant-led ward round 5 days/week</td>
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Transient Ischaemic Attack

• Low risk and high risk; **ABCD2 score has been removed**

• Recommendations **around timing** as opposed to high/low risk

• Patients with a suspected TIA of more than a week, should be seen and assessed as soon as possible (and within 7 days maximum)

• Suspected TIAs within 24 hours of symptoms should be seen in a specialist neurovascular clinic asap, and within 24 hours of symptom onset
Transient Ischaemic Attack

- Patients with suspected TIA should be assessed by a specialist physician (was a specialist in 2012) before a decision on brain imaging is made, except to exclude haemorrhage, on anticoagulants, bleeding disorder, when unenhanced CT should be carried out urgently

- Patients suspected of TIA, T2* MRI imaging should be preferred
Rehabilitation approaches

- People with stroke should **accumulate** at least 45 minutes of each appropriate therapy every day, at a frequency that enables them to meet their rehabilitation goals, and for as long as they are willing and capable of participating and showing measurable benefit from treatment.

- In the first two weeks after stroke, therapy targeted at the recovery of mobility should consist of frequent, short interventions every day, typically beginning between 24 and 48 hours after stroke onset.

- Multi-disciplinary stroke teams should incorporate the practising of functional skills gained in therapy into the person’s daily routine in a consistent manner, and the care environment should support people with stroke to practise their activities as much as possible.

- Healthcare staff who support people with stroke to practise their activities should do so under the guidance of a qualified therapist.
Discharge from hospital

• Before the transfer of care for a person with stroke from hospital to home (including a care home) they should be provided with:
  – a named point of contact for information and advice;
  – written information about their diagnosis, medication and management plan.

• People with stroke should continue to have access to specialist services after leaving hospital, and should be provided with information about how to contact them.
  – any continuing treatment the person requires should be provided without delay by a co-ordinated, specialist multi-disciplinary service;
  – the person and their family/carers should be given information and offered contact with relevant statutory and voluntary agencies.
A stroke early supported discharge team

• Before the transfer home of a person with stroke who is dependent in any activities, the person’s home environment should be assessed by a visit with an occupational therapist. Any person who does not require a home visit should be offered an interview about the home environment including photographs or videos.

• People with stroke who are dependent in personal activities (e.g. dressing, toileting) should be offered a transition package before being transferred home that includes:
  – visits/leave at home prior to the final transfer of care;
  – training and education for their carers specific to their needs;
  – Telephone advice and support for three months.
Recommendations- Early Supported Discharge

• Hospital in-patients with stroke who have mild to moderate disability should be offered early supported discharge, with treatment at home beginning within 24 hours of discharge.

• An early supported discharge team should care predominantly for people with stroke and should provide rehabilitation and care at the same intensity as would be provided if the person were to remain on a stroke unit.
A stroke early supported discharge team should include:

- A co-ordinated multi-disciplinary team that meets at least once a week for the exchange of information about people with stroke in their care;

- information, advice and support for people with stroke and their family/carers;

- management protocols for common problems, based upon the best available evidence;

- close links and protocols for the transfer of care with in-patient stroke services, primary care and community services;

- training for healthcare professionals in the specialty of stroke.
Early Supported Discharge

• A stroke early supported discharge team should be organised as a single multi-disciplinary team including specialists in:
  • – medicine
  • – nursing
  • – physiotherapy
  • – occupational therapy
  • – speech and language therapy
  • – clinical/neuropsychology
  • – with easy access to social work, dietetics, pharmacy, orthotics, orthoptics
  • specialist seating, assistive technology and information, advice and support for people with stroke and their family/carers.
Self management

- People with stroke should be supported and involved in a self-management approach to their rehabilitation goals. People with stroke should be offered self-management support based on self-efficacy, aimed at the knowledge and skills needed to manage life after stroke.
- People with stroke whose motivation and engagement in rehabilitation appears reduced should be assessed for changes in self-esteem, self-efficacy or identity and mood.
- People with significant changes in self-esteem, self-efficacy or identity after stroke should be offered information, support and advice and considered for one or more of the following psychological interventions:
  - increased social interaction
  - increased exercise
  - psychosocial interventions, such as psychosocial education groups
People with stroke in care homes

• One in twelve people with stroke in the UK have to move into a care home because of their stroke and about a quarter of care home residents have had a stroke.

• People with stroke living in care homes should be offered assessment and treatment from community stroke rehabilitation services, to identify pragmatic interventions and adaptations that might improve quality of life.
People with stroke in care homes

• Staff caring for people with stroke in care homes should have training in the physical, cognitive/communication, psychological and social effects of stroke and the management of common activity limitations.

• People with stroke living in care homes with limited life expectancy, and their family where appropriate, should be offered advance care planning, with access to community palliative care services when needed.
Long term support

- People with stroke, including those living in a care homes, should be offered a structured health and social care review at six months and 1 year after the stroke, and then annually. The review should consider whether further interventions are needed, and the person should be referred for further specialist assessment if:

  - new problems are present;
  - the patient’s physical or psychological condition, or social environment has changed.
Long term support

• People with stroke should be offered further therapy if goals for specific functions and activities can be identified and agreed and the potential for change is likely.

• People with stroke should be provided with the contact details of a named healthcare professional (e.g. a stroke co-ordinator) who can provide further information and advice.

• People with stroke should be helped to develop their own self-management plan.