Stroke – acute and community therapies

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Learning objectives

- Improving communications between secondary and primary care as regards therapy recommendations and plans
- Improving management of minor stroke survivors
- Return to driving advice - pathways and recommendations
- The Community Neuro -rehab Service (CNRS) & treatment pathways
- Impact Covid-19 on CNRS service provision

Improving communications

Therapy Performance Standards on HASU:

- Seen by member of therapy team within 24hrs of admission, 7 day service
- Cognitive assessment conducted
- Mood assessed
- Goals set
- Joint care plan provided
- 6 month review referral if provided and referral to Stroke Connect

Discharge communications

Depart discharge summary contains:

- Information on assessments conducted – OT, Physio and SLT
- Information on onward referrals and recommendations re package of care
- All pts who go home with a new package of care or community therapy input are provided with a Joint Care Plan (JCP)
- Provided with local borough information for self referral

A review of our stroke service therapy information provision – A service improvement project informed by patient collaboration

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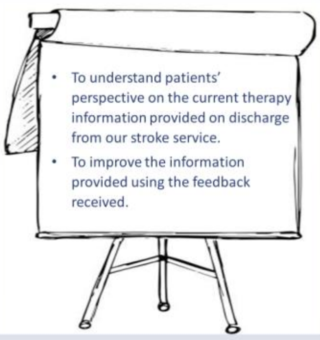
Background

Two thirds of stroke patients are discharged from hospital with a new disability. A quarter of all stroke survivors in England, Wales and Northern Ireland live alone after their stroke. Almost half of stroke survivors feel abandoned after they leave hospital.

The stroke pathway and current model of health provision seeks to move patient care from hospital to community settings. On the Hyper Acute and Acute Stroke Units at Charing Cross Hospital, therapists provide generic information sheets to patients, regarding how to access community stroke resources after hospital discharge.

Aims



Methods

Invitations were sent to all stroke survivors who attend the hospital stroke support group. We held a patient focus group to gain feedback on the content and quality of our information provision. Participants were asked to review our existing information sheets. Opportunity was created for discussion around the needs and priorities of service-user information provision. A copy of out therapy information sheet was distributed for review. Structured questions were used to prompt;

-What information did you receive about your stroke when you were on the ward?

-What information were you given to take home with you on discharge?

-Did you have any difficulties you weren't expecting on discharge?

Themes were derived from the data obtained to reflect key points from the discussion. Feedback was implemented and a subsequent review focus group undertaken.

Results

14 patients attended a 60minute focus group, 1 additional participant provided email responses. Key themes revealed limitations in our current patient communication processes, in the context of the reviewed patient information documents. These themes were:

Theme	Participant quotes
Lack of Information	• "I didn't get any information in hospital" • "They didn't tell me about my difficulties" • "I would have liked information about what happened and why it happened" • "I thought before discharge I would be given a debrief"
Lack of specificity / individualised information	• "Every stroke is different- the information was too broad" • "I didn't know what a TIA was, I thought I knew what a stroke was" • "It didn't sink in because I wasn't like the person on TV" • "Doctors tell you what they're going to do but less about what happened"
Language used	• "Lots of specialist words" • "I couldn't think straight and I couldn't make sense of any of it"
How/when information is provided	• "I was very tired, exhausted, only slept 3-4 hours per night" • "I wanted to be sitting up looking face to face, not have someone leaning over me while I lay in bed" • "The words poured from people, I wanted them to stop, slow down, say less" • "Nothing is joined up (MDT information/follow up services), after 9 years I feel well informed, peer support, stroke association groups helped"
Recall /retention of information	• "I can't remember what was said to me" • "It's like a big jumble trying to remember what everyone said when I got home" • "I had memory problems, I couldn't remember if I'd taken the medications"
Information regarding medication	• "I was unsure about the medication- what to take and when" • "I was nervous about the medications" • "It would be helpful to have information about medications" • "The best explanation was from the pharmacist about warfarin" • "The pharmacist came to explain the medications to me" • "Nobody had told me the side effects of medications"
Information regarding driving	• "I had to ask if I could drive – I was told, we don't know much about dissections, they are unlikely to happen again" • "There was no information about driving; Nobody told me if I could drive again or when"
Information regarding return to work	• "No advice regarding return to work" • "I had to change employment- there was no advice on how to go about this or what to expect on return to work" • "I didn't know how my stroke affected my ability to return to work and do my job, it was embarrassing going back"

Figure 1. Themes & participant quotes

Areas of more generalised need were also identified, relating to communication processes across the multidisciplinary team (MDT), including pharmacists, doctors and nursing staff working on our stroke ward.

We amended our therapy information sheets to reflect the needs and priorities of our service-users'. On a subsequent review focus group, the initial participants were satisfied that the amended information sheets were effective in meeting their needs.

Amended Therapy Information Sheets

WESTMINSTER LOCAL STROKE INFORMATION

Professionals who could help you in the community:

		How to access services or support
	Occupational Therapy (OT) If you are struggling to complete your everyday tasks, an **occupational therapist** may be able to assist you, this may be because you are feeling unusually tired, have reduced concentration or memory or because of new physical difficulties.	Ask your GP to refer to the Community Neuro Rehabilitation Team (03300 033 0333) Or Enquire via 0208 102 5555
	Physiotherapy (PT) If you notice changes in your walking, strength, movement or coordination, a **physiotherapist** may be able to help.	Ask your GP to refer to the Community Neuro Rehabilitation Team Or Enquire via 0208 102 5555
	Speech and Language Therapy (SLT) If you notice changes in your swallow, new coughing when eating/drinking or difficulty with speaking, or understanding written/spoken communication, then an **SLT** may be able to help.	Ask your GP to refer to the Community Neuro Rehabilitation Team Or Enquire via 0208 102 5555
	Neuropsychology If you experience changes in your mood, concentration or memory that are affecting your ability to complete everyday tasks or impacting upon relationships, a **psychologist** or **neuropsychologist** may be able to assist you.	Ask your GP to refer to the Community Neuro Rehabilitation Team OR Self-refer to Community Living Well: Psychological therapies Tel: 02033174200
	Pharmacy If you have questions regarding your medications, speak with your pharmacist or GP and/or raise this at your stroke follow-up appointment.	Contact Your GP

	Social Services If you need support getting food, managing your finances or household tasks, speak to your local social services.	Tel: 020 7641 2500 Web: www.westminster.gov.uk
Stroke association	**Stroke Support** If you feel you would like to understand more about your stroke or life after stroke, meet other stroke survivors and or explore financial support options, community networks/groups and specific support workers are available.	**Stroke Association:** www.stroke.org.uk Tel: 0303 303 3100 **Stroke Support worker** (Bernie): Tel: 020 8102 3879 **My Stroke Guide:** https://www.stroke.org.uk/finding-support/my-stroke-guide **LEGS (London Exercise group for Stroke):** Weekly exercise and advice groups Tuesday 15:00-17:30 W2 5BD Tel:07717 825564 Email: infor@legsphysio.com **ATTEND:** Vocational Rehab Services Tel: 02073072570 **Community Living Well:** Psychological therapies Tel: 02033174200 **Time for Me:** Support service for unpaid/informal carers >50y/o Tel: 02089624141

Driving

In England, Scotland and Wales, driving rules are set by the Driver and Vehicle Licensing Agency (DVLA)

DVLA rules state that after a stroke or single TIA:

You cannot drive for one month. If you drive a car or motorcycle, you usually don't need to inform the DVLA, after one month you may be able to drive again, as long as your GP agrees it is safe for you to do so. For more information visit: https://www.gov.uk/stroke-and-driving.

Return to work

Discuss this with your occupational therapist prior to leaving the hospital. If you do not have on-going community therapy goals to support your return to work, when you feel ready to return, you may choose to link with your occupational health department/employer to discuss conditions of return to work.

If you are unable to return to work you may be eligible for financial support, contact your local Citizens Advice Bureau for information or see Stroke Association website: https://www.stroke.org.uk/finding-support/life-after-stroke/financial-support.

Figure 2. Therapy Information Sheet: Reviewed April 2019/ For review April 2020

Conclusions

It was the aim of the service improvement project to review and modify a therapy information document with patient and public input. Although we succeeded in our aim to review and improve the document, feedback highlighted other areas of need relating to information provision and communication within the stroke MDT.

Through patient and public consultation, we were able to improve the quality of therapists' information provision within our service, as well as identify on-going service development needs. Key development points were indicated, requiring MDT collaboration and involvement of community stakeholders. Further service development and quality improvement work is required to ensure effective MDT communication to educate and signpost patients to address the broad range of needs encompassed in stroke care and post-stroke recovery.

Figure 3. Word cloud: Presentation of participant responses

References

Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). National clinical audit annual results portfolio March 2016-April 2017. Available: http://bit.ly/1NHYlqH Last accessed 03 June 2019.

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Stroke Association Connect Referral

- An outreach phone call from trained Stroke Association Connectors - provides reassurance, supports with any immediate concerns, connects people to ongoing support they can access at any point in their recovery journey.
- Offer of a second outreach call 1 to 4 weeks later.
- Regular follow-on information, via email or post, to support recovery.
- Connection to other Stroke Association support as needed, including peer support.

Minor Strokes

- No post discharge pathway for minor strokes unlike other strokes with more obvious impairments
- Service users have told us that they experience numerous hidden impairments and accessing services is challenging
- Difficulties experienced are often in the domain of cognition, mood, fatigue and higher level physical functioning such as returning playing to sport

Trump Says He 'Aced' a Cognitive Test. What Does That Really Mean?

GP feedback on his experience

- Left thalamic stroke, 50 y/o, ACE III 99/100, independent on ward

Whilst on the ward you really do not do much, you walk to the bathroom and have brief conversations. I did not even have a shower. When I got home I realised that whilst I had made a good recovery …. I had problems with my co-ordination and walking longer distances.

I was aware I needed early input from the rehab team and contacted my GP who arranged the referral to the rehab team over the phone. I feel this happened as I pushed for it and my GP acted promptly (perhaps partly out of professional courtesy)

The follow up phone call should be after 5 days and your team should make the appt referral for rehab. the referral needs quite a lot of detailed info. I think patients may struggle with access to their GP to get appt referral in place. And we all know time is of the essence.

Return to work

Attend ABI provide support for:

- 16-25 year olds
- finding work
- family and carers
- returning to work
- volunteering
- understanding ABI's

abinavigator@attend.org.uk or 020 7307 2570

Driving after stroke or TIA

You are not allowed to drive for a month after a stroke or transient ischaemic attack (TIA). Some people have to stop driving for longer, or will not be able to drive again. This guide helps you understand what to do if you are a driver, including when to tell the DVLA (DVA in Northern Ireland).

Key points

https://www.stroke.org.uk/sites/default/files/driving_after_stroke.pdf

QEF Mobility Services

Tel: 020 8770 1151 or mobility@qef.org.uk

Spasticity Management

- Charing Cross Neuro Rehab Unit – referral to Dr Meenakshi Nayar

- Alderbourne Rehabilitation Unit, Hillingdon Hospital Dr Ajoy Nair

- National Hospital for Neurology and Neurosurgery Telephone: 020 3448 3112, service manager - Dr Val Stevenson val.stevenson1@nhs.net

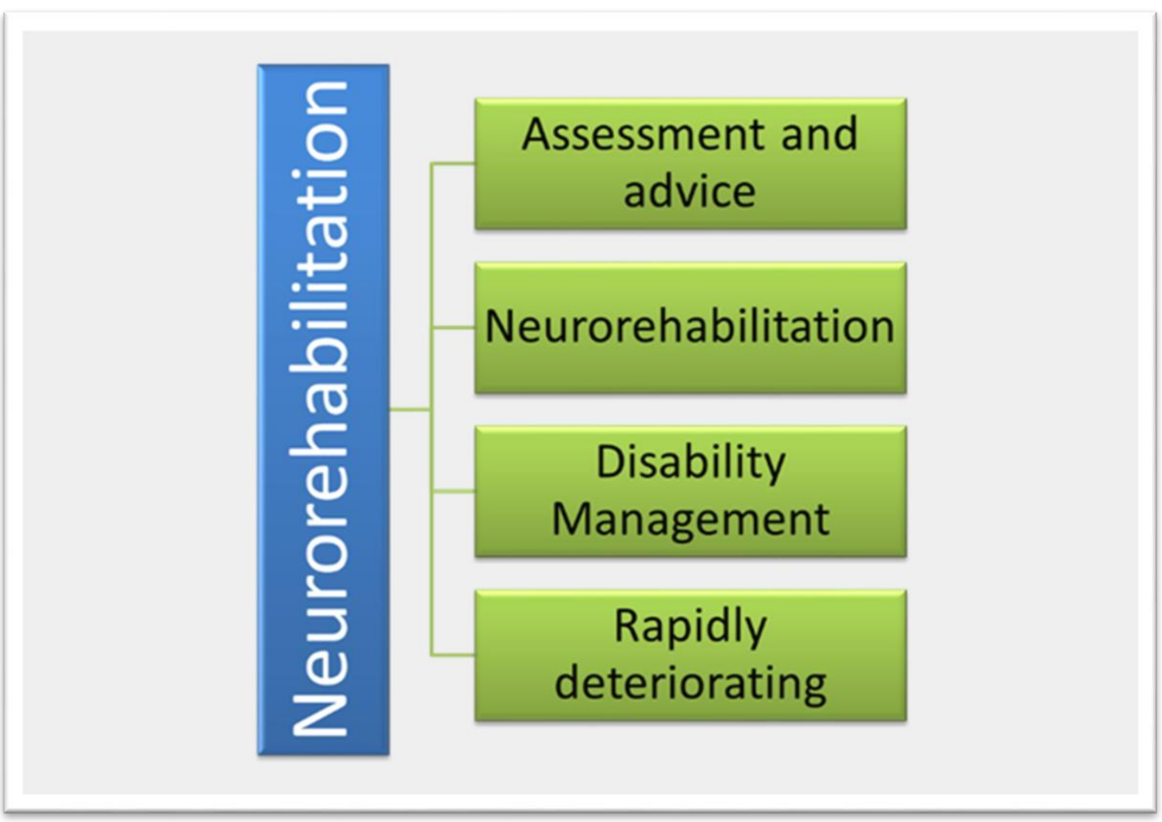
Community Neurological Rehabilitation Service (CNRS)

- Integrated multidisciplinary team
- Specialist neurological rehabilitation along agreed pathways of care (6 in total; high intensity ESD & SNROS)
- Borough based teams with Clinical Leads that work across tri-borough

Community Neurological Rehabilitation Service (CNRS)

- Referrals source (GPs vs. Acute)
- Access to service is based on borough resident **or GP**
- Commitment to best practice, evidence-base & research

Service Development: Care pathways

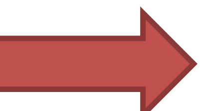


Care Pathways

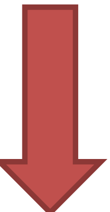
	Pathway	Capacity	Direct visits	Length
Time sensitive Rehabilitation	SNROS	4 clients	Daily intensity	Up to 8 weeks
	ESD	18 clients	Daily intensity	Up to 6 weeks
Neuro Rehabilitation service	Rapidly deteriorating	No limit	As clinically indicated across all of MDT	Discussion in supervision/team
	Advice and Assessment	No limit	2 sessions	2 - 3 weeks
	Neurorehabilitation	No limit	As clinically indicated across all of MDT	4 – 6 weeks
	Disability management	No limit	As clinically indicated across all of MDT	4 weeks

Service Development: Triage

Hear it:
- Time consuming process

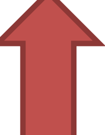


Analyse it:
- All bandings did triage.
- Inconsistencies in decision making and experience



Discuss it:
- B7s piloted a new triage system
- Training SPA to manage referrals accurately and timely

Change it:
- SOP developed
- ‘Triage caseload’ on system 1 to prevent unassigned referrals



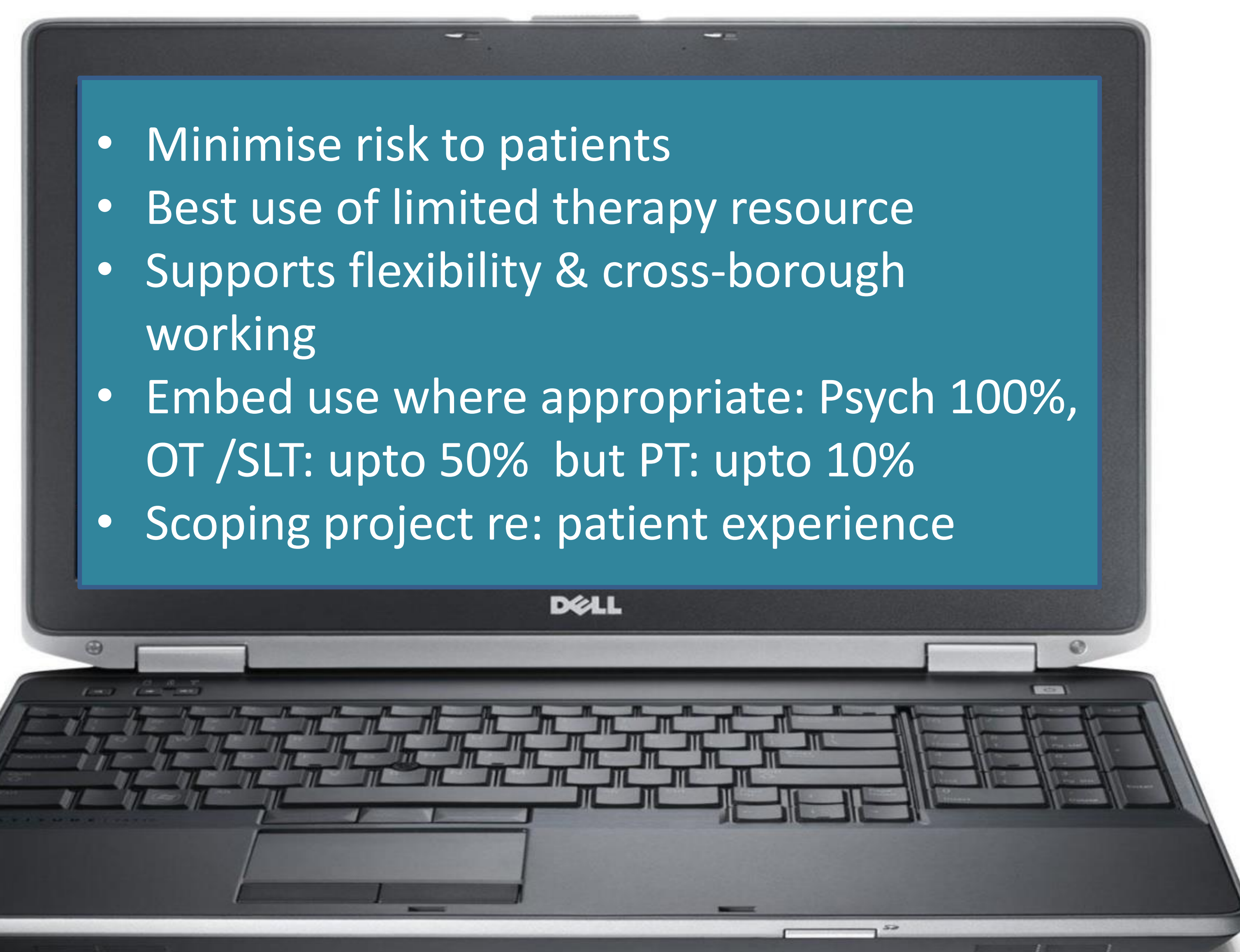
Evaluate it:
- Better waiting list management
- More clinical time
- Positive staff feedback
- **Patient Safety Award**

Better outcome
Better experience
Better use of resources

Impact of Pandemic

- Community services mandated to supported discharge facilitation for Acute
- Patient isolation
- Staff redeployment
- Staff isolation
- Move to virtual provision (MS Teams; staff. Blue jeans; patients)

Virtual Therapy



Phases of recovery plan

Phase 1 May 4	Phase 2 June 15	Phase 3 July- now	Phase 4 Vaccine?
Time Sensitive Rehab (ESD, SNROS & Rapidly Progressive) Resettlement for high risk (red) clients all other pathways	Time Sensitive Rehab (ESD, SNROS & Rapidly Progressive) Intervention for high & moderate risk (red & orange) clients Assessment & Advice, Neuro Rehab & Disability Management	Time Sensitive Rehab (ESD, SNROS & Rapidly Progressive) * Intervention for high, moderate and low risk (red, orange and yellow) clients Assessment & Advice, Neuro Rehab & Disability Management *Ongoing minimisation of face to face contact consistent with PHE guidance*** 	Resumption of all pathways as commissioned Resumption of groups and outpatient clinics Applying learning / good practice from prior phases.

Conclusions

- Shifting demographic of community patients?
- Access to community services
- Shift to virtual provision (NB. patient preference)
- Working in partnership (primary, secondary and tertiary)