MANAGEMENT OF STROKE AND TRANSIENT ISCHAEMIC ATTACK POLICY & PROCEDURES

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Page:	1of 5

Background

There is overwhelming evidence that the most important intervention that can improve outcomes for all people with stroke is the provision of organised stroke services, a vital component of which is a stroke unit. Without an organised stroke service, adherence to recommendations about specific interventions is likely to have little impact on outcomes for people with stroke. The two critical areas of stroke management where a change of practice would make an important difference to outcomes for people with stroke are, all District Health Boards should provide organised stroke services and, all people admitted to hospital with stroke should expect to be managed in a stroke unit by a team of health professionals with expertise in stroke and rehabilitation.

Purpose

The purpose of this policy is to establish processes to ensure there is compliance with the New Zealand Guidelines for the Management of Stroke, November 2003 and New Zealand Guidelines for the Assessment and Management of Transient Ischaemic Attack (TIA) 2008.

Scope

This policy and its related procedures apply to the management of patients admitted to Taranaki District Health Boards (TDHB) hospital and specialist services with stroke or TIA . It has particular significance for staff working in clinical settings.

Definitions

Stroke

The World Health Organisation (WHO) defines stroke as: a clinical syndrome typified by rapidly developing signs of focal or global disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than of vascular origin.

Transient Ischaemic Attack

A Transient Ischaemic Attack (TIA) is defined as stroke symptoms and signs that resolve within 24 hours (NZ TIA Guideline 2008)

Roles and Responsibilities

The TDHB is responsible for ensuring :

- That people with stroke have access to organised stroke services.
- A hospital wide policy and related procedures for the management of stroke and TIA are in place.
- Training and education occurs for staff in relation to the policy and related procedures.
- Regular review of the policy to assess currency and relevance.
- Adequate support and supervision for staff.
- Activities are properly resourced and evaluated.

The Stroke team is responsible for ensuring

- Clinical oversight and support to acute and inpatient rehabilitation teams whatever their location.

Clinical Nurse Managers will ensure:

- That there are unit level procedures in place for nursing staff based on the hospital wide policy and procedures.
- That nursing care is provided by nurses that have undertaken training and education in the management and care of patients with stroke/TIA.
- The stroke nurse is responsible for staff and whanau education in conjunction with the Clinical Nurse Educator/Clinical Nurse Manager of the stroke unit or ICU/CCU/HDU.

Allied Health Coordinator/Advisors will ensure :

- That intervention is provided by allied health staff that have undertaken training and education in the management and care of patients with stroke/TIA.
- That intervention in the acute phase is provided by the acute ward allied health staff and by the Older Peoples Health and Rehabilitation (OPHRS) allied health staff for ongoing rehabilitation needs.

Duty Manager responsibilities include

- Coordination of bed management in liaison with ICU or the wards' shift co-ordinators so that staff are able to receive the patient within a maximum six hour timeframe.

Hospital and Specialist Services staff : Doctors, Nurses, Occupational Therapists, Physiotherapists, Dieticians, Pharmacists, Speech Language Therapists, Ward/Unit receptionists, Orderlies, HCAs , Ambulance, Team Leaders and Managers.

- Have a responsibility to be aware of this policy and associated procedures.

Te Roopu Paharakeke Hauora (TDHB Maori health Team) responsibilities include

- Supporting TDHB staff to deliver culturally appropriate health and disability services for Maori patients with stroke or TIA. Wherever possible staff involved in stroke care will seek Maori cultural input (Kaimahi Hauora) and include patients whanau at times of assessment, goal setting, discharge planning and, facilitate access to traditional healing (karakia, rongoa, mirimiri) Te reo me nga Maori as appropriate.

Compliance

An audit will be performed on a regular basis that focuses on key aspects of this policy and procedures will be developed and implemented to assess compliance.

Supporting Information

This policy and related procedures, including flowcharts are based on the New Zealand Guidelines for the Management of Stroke, November 2003 and New Zealand Guidelines for the Assessment and Management of Transient Ischaemic Attack (TIA) 2008.

This policy and related procedures are based on the new Zealand protocols for the management of stroke and transient ischaemic attack.

Stroke Management Procedures & Issues for Consideration

Taranaki Base Hospital Flowcharts

Taranaki Base Hospital Stroke Flowchart

Taranaki Base Hospital TIA Referral pathway

Hawera Hospital Flowcharts
Hawera Hospital Stroke/TIA pathways

Admission Process

- When a stroke/TIA diagnosis is made and the patient requires admission to hospital, the Emergency Department clinical nurse coordinator or triage nurse will notify stroke unit staff or ICU staff (depending on the acuity of the patient) and the Duty Manager.
- Admission will be to the ICU/CCU/HDU, if it is deemed that the patient requires intensive care therapy or otherwise the stroke unit.
- The DM will coordinate bed management in liaison with ICU or the wards' shift co-ordinators. Staff will then arrange to receive the patient within a maximum six hour timeframe.
- For Hawera patients, transfer will be arranged as soon as possible to the Emergency Department at Taranaki Base Hospital. Stroke unit staff will then arrange to receive the patient within a six hour timeframe. Contact Kaimahi Hauora on admission if patient is Maori.
- The patient will remain under the care of the general medical team and be managed (with oversight from TDHB's designated stroke clinician and stroke team) until acute investigation and treatment has been completed and patients are medically stable.(It is envisaged average length of stay under the acute service will be 5 days).
- Patients requiring ongoing rehabilitation > 5-7 days will be transferred from the general medical team to the OPHRS team following discussion and agreement between both consultants.

Bed Management

Where there are conflicting needs, the following bed management rules will be applied:

- Where bed availability comes down to a choice between an OPHRS pickup and a stroke/TIA admission then the priority should be the stroke/TIA patient.
- When the scenario arises that the ward is at full capacity (ie no beds) and there is a confirmed stroke/TIA patient in ED, outlier patients in ward 1 should be identified and a decision made by the CNM /designate around the most appropriate patient to be transferred out to accommodate the stroke patient.
- Where the scenario arises that there is a severe stroke pt that has a NFR order in place and is being admitted for comfort cares transfer of the patient to Ward 1 should still occur.
- If a stroke/TIA bed is still not available when the above has been applied, the patient will be admitted to another ward and will be cared for by the general medical team as an outlier. Nursing oversight will be provided by the designated stroke nurse until a bed becomes available in the designated stroke unit at which time the patient can be transferred.

Discharge Planning

In general, an estimate of the likely length of inpatient care required should be made within 48-72 hours of hospital admission, in consultation with the multidisciplinary team.

- If inpatient care of less than another 4-5 days seems likely then a pathway for the patient to be discharged home directly should be commenced depending on home circumstances.
- If inpatient care of a further 7-10 days or longer seems likely then a pathway for the patient to be transferred to the OPHRS team should be progressed.
- Regardless of planned discharge process, all patients should continue active multidisciplinary rehabilitation during their stay unless a clear decision has been made that an individual patient is for comfort measure cares, rather than active rehabilitation.
- NB: If a patient is not for active treatment and rehabilitation, a decision regarding appropriate discharge destination may be necessary e.g. hospital level of care placement. These decisions are complex and should be made on an individual patient basis with full involvement of the whole multidisciplinary team, and where possible the patient and the patients family/whanau. Whanau Hui should be considered, to keep the whanau informed of progress and certainly prior to discharge.

Discharge Destination

- Patients will be discharged to their previous residence with or without support services of rapid recovery (< 5-7 days) for example : Intermediate Care Assessment and Treatment Team input or single discipline follow-up eg continued physiotherapy or speech-language therapy or occupational therapy.
- Rest home or hospital level nursing care will be considered if not a suitable candidate for rehabilitation eg unable to actively participate in rehabilitation or severe co-morbidities.

Discharge Planning for Maori

Maori with stroke are more likely to be discharged from hospital to live with others/whanau than to live on their own with support services or to a rest home/private hospital. (Mc Naughton 2002a). Evidence shows that young Maori experience more difficulties returning to work than non Maori, particularly in the presence of untreated psychiatric co morbidity (Glozier et al 2008). Rural location, reduced access to transport and insecure tenure also create barriers in access to outpatient clinics and social whanau activities. These should be considered when planning discharge.[1]

Ethical Issues

The management of stroke patients often requires careful ethical consideration. Prognosis is often uncertain in the early stages after a stroke. Decisions not to treat on the basis of a probable poor outcome very often become self fulfilling prophecies. Early decisions to withhold possible life-prolonging measures such as intravenous fluids and antibiotics should not be made unless the outlook is clearly hopeless. An example would be a patient with a history of several previous strokes, severe dementia and poor functional status[2].

[1] NZ Clinical Guidelines for Stroke Management 200-Consultation Draft

[2] Gurchanran S Rai. Medical Ethics in the Elderly. Second edition. Radcliffe Medical Press. Oxford