Stroke Pathway Factsheet

Fact sheet for Acute Stroke Unit (ASU):

Total of 20 beds with 2 x boarding spaces used when capacity needs to be increased

Vast majority of stroke patients will not meet the criteria for boarding however

A patient is seen in A+E by the Stroke Emergency Assessment Team (SEAT) which consists of a consultant/ACP and a stroke clinical nurse specialist

Once a working diagnosis of stroke is made, the patient needs to be admitted to the Hyper Acute Stroke Unit (HASU) on ASU

Some patients may be identified as candidates for thrombectomy and transferred to the Queen Elizabeth Hospital in Birmingham for the procedure. Once they have been managed there, they are repatriated back to Worcestershire

Therapies are commissioned to provide a 7 day service, except for SLT who offer 6 days (no cover on Saturdays)

Patients admitted to ASU can access dietetics and orthoptics as well

The aim of the hyper acute and acute phase is to provide medical management, early rehabilitation and to medically stabilise the patient

At times, patients are too unwell with an uncertain recovery plan and may end up going down a palliative/fast track route as opposed to active rehabilitation

Sometimes, when there is not any bed capacity on ASU, patients will be admitted to other wards in the hospital. These patients will still be able to access stroke therapies but will be medically managed by the ward medics

Discharge planning starts after initial assessments have been completed and plans remain fluid and flexible until a patient is medically fit - this allows for robust MDT discussion and to ensure patients are discharged on the appropriate pathways when they leave hospital

Patients will either be discharged to in-patient rehabilitation at Evesham Community Hospital, home with Community Stroke Services, home with care support or to community beds where care needs will be further assessed

Fact sheet for Evesham community hospital:

Total 49 inpatient beds, 32 commissioned for stroke patients

Access to two therapy gyms

Therapy sessions are timetabled in the day before, dependent on need, unlikely 7 days a week

For actively rehabbing patients we will try and complete a motor therapy session (may be OT or PT) most days

Upper limb, cognition, personal care and kitchen assessments will be completed as appropriate

Currently covering 1 out of 2 days at a weekend, 1 qualified staff member, 1 assistant all day – often new patient assessments and small cohort of additional patients

Disciplines: Physio, OT, SLT, therapy assistants, limited dietetics, limited neuropsychology, no orthoptics (advice only or outpatient appointments), ACPS, ACP specialising in spasticity BoNT available by assessment, GP cover, rehab nurses and HCAs, social workers, leisure facilitators.

Medically – cover by GPs and ACPs within work hours during the week, out of hours GPs weekends and after hours, 999 support.

A family stroke support and education group, run bi-monthly

Due to complexity of discharges, often patients / families will have a future planning meeting prior to discharge to fully explain and plan support for discharge from hospital

Social workers attached to each ward, they will complete mental capacity assessments for changes in discharge destination

Continuing health care checklists and potential decision support tools will be done as an inpatient for patients with significant care needs for discharge.

Joint sessions can be completed with family members on request – these will need to be completed fairly across wards and patients (as we try and ensure the gym spaces aren't too busy)

There are access to gardens which families and patients can access, as well as bring their dogs in from home.

Groups were run consistently pre- covid and are starting to get back to running – such as a communication group, breakfast clubs and upper limb groups

Fact sheet for Community Stroke Services (CSS)

Community rehabilitation service accessed in patients' homes.

Team consists of: Speech and Language Therapy, Physiotherapy, Nurses, Occupational Therapy and Rehabilitation Assistants.

Patients can be referred into the service for active rehabilitation or specialist advice/support from Acute services, GP services, Rehab hospitals and Stroke Association and/or other health care providers. Patients can be referred for Early Supported Discharge (ESD contacted within 24hrs of referral-meet and greet at patients home at point of discharge), Mild stroke (may require Intensive therapy), Complex Stroke (patients who require POC or discharged to NH/RH).

Patients enter the service for a up to 6-week rehabilitation period, not all patients require 6 weeks and can be discharged at the point of no further input being indicated as no goals identified.

CSS covers across 7 days a week (only ESD at the weekend, 1-2 qualified & 1 rehab assistant).

Patients contacted up to 72 hours after receipt of referral to complete triage telephone conversation with patient/NOK or carer (if from nursing home). Triaged for priority of interdisciplinary assessment dependent on number of factors e.g., changes since referral, concerns re. safety, swallowing concerns, spasticity, seating etc.

Patients can opt out from receiving support from Community Stroke Service if managing and feel have no current goals to achieve. They can be discharged from service at this point or can be discharged to 6-month review clinic and given opportunity for 12-month review (discharged thereafter).

Patients will be assessed by registered member of multidisciplinary team (IDT) in either discipline e.g. physiotherapy, nursing, speech and language, occupational therapy. From assessment, the therapist will identify goals and areas which need specific discipline management. Patient receives folder signposting team information, post stroke education via QR codes/leaflets.

Patient will be assessed by the relevant clinicians who are required for involvement and devise treatment plans dependent on area of need and intensity e.g., X5 SLT. This is reviewed weekly/bi-weekly and discussed during goal setting weekly.

Disciplines and Rehab assistants complete goal setting weekly discussing whole caseload, upcoming IDTs and discharges. Reviewing goals, setting new goals, and having multidisciplinary discussions regarding patient progress and concerns.

Community stroke team regularly involved with educating carers and family, liaising with social work teams, liaison with other medical services to ensure patient receiving appropriate post-stroke care and prevention.

Community Stroke have access to equipment stores to order equipment & will go out to assess/fit equipment as required. Also have access to specialist seating for patients living in their own homes (unable to provide to care homes due to funding but will provide education around seating as required and have access to x2 specialist chairs for assessment/trial purposes).

Joint sessions are completed with relevant disciplines as appropriate regarding patient goals e.g. may be taking patient out into community (cafe/shops) to review in this environment as patient's wishes.

Stroke Association referral can be made at any point by the team or themselves.

Family/carer support can be received from Worcestershire Carers' Association.

6- and 12-month reviews offered to all ESD and Mild stroke patient's, at present.

After 12 months of admission to the service, patient is discharged from the caseload and referred on to other services, as required. Often, we are a source of information, advice and guidance for any patient who has been previously associated with us.

Fact Sheet for Stroke Association

131 Coordinator hours

Cover a 5-day service, Monday – Friday covering core hours

Referrals accepted once Stroke Survivor has returned home.

Do not support people in care homes currently.

Every referral is contacted and support from our coordinators offered, an initial assessment of needs completed if support accepted.

Support delivered face to face in a person's home and/or over the telephone – person centred approach.

Support includes information giving, signposting, referrals to other support agencies, emotional support, advocacy and advice.

Areas of support are around what matters to the stroke survivor and their family. This is varied, however the top 5 identified needs in more recent years includes Understanding of stroke, Benefits & Finance, supporting with blue badge applications/mobility, Support networks and Needs of the Carer.

Ongoing support for up to 12months post stroke, including follow up calls and discharge conversations – again, this is person led and based on client's level of need.

Support with Hardship grants up to £150 for families with severe financial difficulties. These grants are provided in the form of supermarket vouchers.

Links to Stroke Group Network – a national support network of stroke clubs and groups Stroke Group Network is a community of stroke support groups across the UK. From structured group sessions to informal café meet-ups. You can search for groups on website using a map or town/postcode. You can then contact the lead volunteer directly to make an enquiry or arrange a visit. Th Stroke Association has a national partnership with - Ability Net, Interact & Self-Help UK. Professionals can join local forums which includes all groups and volunteers across their locality.

Signposting to local groups in the area: Coordinators know the local Stroke Association groups and can support individuals to access them. They are also able to signpost to other voluntary sector support groups and information. For example, local Age UK activity, Including Men in Sheds and local sports groups who run accessible and seated exercise groups.