London Ambulance Service NHS
NHS Trust

Stroke Care Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: is to ensure that people suffering a stroke will receive assessment and management by the Trust in accordance with national best practice guidance

Sponsor Department: Medical Directorate

Author/Reviewer: Assistant Medical Director. To be reviewed by July 2015.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
06/08/2012	2.1	IG Manager	Document Profile & Control update
13/07/2012	1.3	IG Manager	Document Profile & Control changes
03/07/2012	1.2	Assistant Medical Director	Updated monitoring section, Responsibilities, and S.8.5
03/08/2011	1.1	Assistant Medical Director	Minor Amendments to Section 4 following ADG - delete ECP
16/01/2011	1.0	Assistant Medical Director	Submitted to CQSEC and ADG for approval
18/11/2010	0.4	Assistant Medical Director	Further amendments to Section 7 – development of networks and pathways
15/10/2010	0.3	Assistant Medical Director	Minor amendments to Section 7 – Development of Networks and Pathways
27/09/2010	0.2	Governance and Compliance Manager	Committees updated and general reformat in line with Trust format
29/07/2010	0.1	Assistant Medical Director	New Policy

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

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Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP056	Core Training Policy (inc. TNA)	
OP014	Managing the Conveyance of Patients Policy and Procedure.	
JRCALC Guidance	Clinical Practice Guidelines for Use in UK Ambulance Services	

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in Policy and Procedure File remains the controlled master copy. Any printed copies are neither controlled nor substantive.

1. Introduction

1.1. The London Ambulance Service NHS Trust (the 'Trust') supports the guidance for the assessment and care of patients believed to be suffering a stroke as detailed in the Clinical Practice Guidelines for Use in UK Ambulance Services, (JRCALC guidelines)

1.2. The Trust also recognises that special arrangements are needed to ensure that these patients are taken to the most appropriate facility for their condition.

1.3. The Trust will work closely with, and support the Pan London Stroke Board and its local groups to ensure the best possible care for these patients.

2. Scope

This Policy outlines the Trust's position on the response to, assessment, diagnosis and treatment of suspected cases of stroke.

3. Objectives

3.1. Ensure that the London Ambulance Service NHS Trust staff are able to identify and respond to patients with suspected stoke in a timely manner, perform an adequate assessment of their condition and convey them to an appropriate facility.

3.2. The Trust acknowledges the guidance provided in the JRCALC Guidelines

4. Responsibilities

4.1. The **Clinical Quality Safety and Effectiveness Committee** has overall responsibility for stroke care in the London Ambulance Service NHS Trust.

4.2. The **Medical Director** has responsibility for the implementation of this policy in accordance with the JRCALC guidelines and for ensuring that all staff deliver care in accordance with this policy.

4.3. The **Assistant Directors of Operations and Ambulance Operations Managers** have responsibility for the day to day delivery of staff and vehicles to allow the treatment and conveyance, (or discharge) of stroke patients to an appropriate care facility.

4.4. The **Assistant Director of Operations (Control Services)** is responsible for ensuring that handling of 999 calls relating to , and mobilisation of resources to patients suspected of suffering a stroke is in accordance with current guidelines and policies.

4.5. All **Clinical Staff** have a responsibility to ensure that they maintain their assessment, diagnostic and treatment skills (as appropriate) in line with their training. This includes (but is not limited to) Duty Station Officers (DSOs), Team Leaders (A&E and PTS), Paramedics, Student Paramedics, Emergency Medical Technicians, Urgent Care Staff, Patient Transport Service (PTS) and Control Services staff.

4.6. The **Clinical Audit and Research Unit (CARU)** is responsible for the clinical review of all potential stroke patients (as defined by hospital destination and clinical coding) to monitor clinical performance and compliance with Trust and National guidance.

5. Definitions

5.1. **FAST Positive**
A patient with one or more positive findings on the Face Arms Speech Test

5.2. **HASU**
Hyperacute Stroke Unit

5.3. **ROSIER Test**
The 'Recognition of Stroke in the Emergency Room' diagnostic tool aimed at identifying patients who do have a stroke (particularly involving the posterior cerebral circulation) despite having a negative FAST

6. General Policy

6.1. The Trust works to the guidance provided in the JRCALC Guidelines and all staff will be made aware when there are updates and changes to this information.

6.2. Over and above providing basic and advanced clinical care in line with approved clinical guidelines and Trust policies ambulance crews will deliver appropriate clinical care to patients believed to have suffered a stroke.

6.3. Patients will be conveyed to the most appropriate centre for their condition in accordance with OP014 Managing the Conveyance of Patients Policy and Procedure.

7. Stroke Networks and Pathways

The Trust will support a coordinated approach to Stroke care in London and work closely with pan-London and local networks.

7.1. **Development of care pathways for appropriate referral to specialist facilities**

7.1.1 The Trust will work closely with local and pan-London Stroke networks to develop appropriate pathways for patients believed to be suffering a stroke. The LAS is represented on the Pan-London Stroke and Cardiac Network Board, (Deputy Director of Strategic Development) and the Stroke Clinical Advisory Group (Medical Directorate), which both meet on a regular basis. The LAS also attends local and sector meetings on an as-and-when-required basis.

7.1.2 Patients will be transported to the most appropriate centre for their clinical condition.

7.1.3 All Patient Report Forms where crews indicate that the patient has suffered a stroke are subject to clinical audit by the Trust's Clinical Audit and Research Unit (CARU). A report is prepared on a monthly basis, detailing clinical care, call and journey times and destination choice. The results of this audit are fed back to operational managers to allow them to monitor individual complex performance and encourage appropriate care.

7.1.4 The stroke network clinical directors are encouraged to contact the Medical Directorate to enquire about the prehospital care given, including patient destination choice and to report on patient outcomes.

7.2. **Participation in Stroke Network(s) within the Healthcare Community**

7.2.1 The Trust will support and work with the networks and specialist units to monitor capacity and assist in balancing workload across all units.

7.2.2 The Trust will provide for the transfer of critically ill patients, and those in need of life-saving interventions from local emergency departments to specialist units.

7.2.3 The Trust will support the stroke networks in raising awareness about stroke in the medical and general community.

8. Education

8.1. Training in the recognition and management of stroke will be delivered in accordance with the Trust's Training Needs Analysis ((TNA) see TP056 Core Training Policy)

8.2. Emergency Operations Centre Staff will be trained to identify patients believed to be suffering from a stroke using approved decision support software, and to mobilise appropriate resources in an appropriate time frame.

8.3. Clinical Staff of all levels will be trained to recognise patients believed to be suffering from a stroke using clinically accepted tools such as FAST and ROSIER.

8.4. Staff will be made aware of, and be advised how to access the most appropriate care pathway for their patients.

8.5. All stroke care training is in line with the current clinical practice guidelines issued by JRCALC, which sets out the minimum standards that must be achieved. Whenever there is a major change in an associated clinical guideline this will be communicated via update training for all relevant staff.

8.6. Periodically, JRCALC may review their guidance and following any updates will provide a gap analysis, highlighting any significant changes to practice. This is documented in every copy which is distributed to staff, with a lead in period stated which allows for queries or extra educational needs required. The Medical Director will ensure that all relevant clinical staff are aware of these changes to practice via the Medical Director Bulletin process.

8.7. Update training requirement for all operational staff responding to general accident and emergency calls involving stoke emergencies will be carried out as indicated in the TNA. Staff should indicate during the PDR process whether they require update training in stroke care and will also be reminded of any changes to clinical practice as outlined above.

8.8. Non-attendance against the stroke care training, as per the TNA, will be monitored and reported via Promis/ Learning Management System to the Training Services Group. Such information will then be forwarded to the relevant Assistant Directors of Operations for subsequent action, as outlined in the Core Training Policy.

8.9. Records of all training and education will be kept in the Trust's Education and Development Department

IMPLEMENTATION PLAN				
Intended Audience	All Clinical and EOC staff			
Dissemination	Available on The Pulse			
Communications	Revised Procedure to be announced in the RIB and a link provided to the document			
Training	Induction, Annual CPD updates and team briefing			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring AND Tool used**	**Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**
Duties (assessment, diagnosis and treatment regimes) (Paragraph 4) including the The minimum standards of stroke care training that must be achieved (Paragraph 8)	Monthly audit of stroke performance Annual PDR process will also monitor the continuous professional development of staff with regard to stroke care	Clinical Audit and Research Unit will report results to the Clinical Quality Safety and Effectiveness Committee. CARU also reports Nationally agreed Clinical Quality Indicators and compliance with Care Packages to the Department of Health	Quality Committee and Clinical Safety and Effectiveness Committee	CARU Monthly report allows complexes and areas to track performance and identify areas of good practice and areas for development
Care pathways in place for referral to specialist secondary care centre(s) (Paragraph 7.1)	Relationships with Stroke and Cardiovascular Networks	Medical Directorate Lead for Stroke		
How the organisation participates in stroke network(s) (Paragraph 7.2)	Regular communication with Stroke and Cardiovascular Networks			