NICE National Institute for Health and Care Excellence

NICE quality standard

Stroke in adults

Quality standard

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This standard is based on CG68.

This standard should be read in conjunction with QS15, QS71, QS92, QS93, QS100 and QS99.

Introduction and overview

This quality standard covers care provided to adult stroke patients by healthcare staff during diagnosis and initial management, acute-phase care, rehabilitation and long-term management.

Introduction

Stroke is a preventable and treatable disease. It can present with the sudden onset of any neurological disturbance, including limb weakness or numbness, speech disturbance, visual loss or disturbance of balance. Over the last 20 years, a growing body of evidence has overturned the traditional perception that stroke is simply a consequence of ageing that inevitably results in death or severe disability. Evidence is accumulating for more effective primary and secondary prevention strategies, better recognition of people at highest risk who are most in need of active intervention, interventions that are effective soon after the onset of symptoms, and an understanding of the processes of care that contribute to a better outcome. There is also now good evidence to support interventions and care processes in stroke rehabilitation. In the UK, the National Sentinel Stroke Audits have documented changes in secondary care provision over the last 10 years, with increasing numbers of patients being treated in stroke units, more evidence-based practice, and reduced mortality and length of hospital stay. This quality standard provides clinicians, managers and service users with a description of what a high-quality stroke service should look like.

Overview

The quality standard for stroke requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole stroke care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to people with stroke.

List of statements

Statement 1. People seen by ambulance staff outside hospital, who have sudden onset of neurological symptoms, are screened using a validated tool to diagnose stroke or transient ischaemic attack (TIA). Those people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, are transferred to a specialist acute stroke unit within 1 hour.

Statement 2. Patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.

Statement 3. Patients with suspected stroke are admitted directly to a specialist acute stroke unit and assessed for thrombolysis, receiving it if clinically indicated.

Statement 4. Patients with acute stroke have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they have an ongoing management plan for the provision of adequate nutrition.

Statement 5. Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.

Statement 6. Patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment are treated in a specialist stroke rehabilitation unit.

Statement 7. Patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it.

Statement 8. Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers.

Statement 9. All patients after stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment.

Statement 10. All patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.

Statement 11. Carers of patients with stroke are provided with a named point of contact for stroke information, written information about the patient's diagnosis and management plan, and sufficient practical training to enable them to provide care.

In addition, quality standards that should also be considered when commissioning and providing a high-quality stroke service are listed in related NICE quality standards.

Quality statement 1: Ambulance screening and transfer to an acute stroke unit

Quality statement

People seen by ambulance staff outside hospital, who have sudden onset of neurological symptoms, are screened using a validated tool to diagnose stroke or transient ischaemic attack (TIA). Those people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, are transferred to a specialist acute stroke unit within 1 hour.

Quality measure

Structure:

(a) Evidence of local arrangements to ensure that a validated tool is used by ambulance staff to screen for stroke or TIA in people with sudden onset of neurological symptoms.

(b) Evidence of local arrangements to ensure those people with persistent neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, who have a possible diagnosis of stroke, are transferred to a specialist acute stroke unit within 1 hour.

Process:

(a) Proportion of people with sudden onset of neurological symptoms who are screened for stroke or TIA outside hospital by ambulance staff using a validated tool.

Numerator – the number of people screened for stroke or TIA using a validated tool.

Denominator – the number of people with sudden onset of neurological symptoms seen outside hospital by ambulance staff.

(b) Proportion of people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, who have a possible diagnosis of stroke, who are transferred to a specialist acute stroke unit within 1 hour.

Numerator – the number of people who are transferred to a specialist acute stroke unit within 1 hour.

Denominator – the number of people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, who have a possible diagnosis of stroke.

What the quality statement means for each audience

Service providers ensure that there are agreed local policies and protocols for ambulance staff to use validated tools to screen for stroke or TIA in people with sudden onset of neurological symptoms outside hospital, and that there is immediate access (1 hour) to a specialist acute stroke unit for those with persisting neurological symptoms.

Ambulance personnel ensure that they use a validated tool to screen for stroke or TIA in people with sudden onset of neurological symptoms outside hospital. They ensure that people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, are transferred to a specialist acute stroke unit within 1 hour.

Commissioners ensure that services are in place for ambulance staff to assess people who have sudden onset of neurological symptoms outside hospital using a validated tool. They ensure that services are in place for people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, to be transferred to a specialist acute stroke unit within 1 hour.

People with sudden onset of neurological symptoms can expect to be assessed by ambulance staff using a validated tool to diagnose stroke or TIA. People with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, can expect to be transferred to a specialist acute stroke unit within 1 hour.

Definitions

The goal of 1 hour set by this statement has been selected to take into account the differences between urban, rural and remote locations. However, trusts can set appropriate targets for their local service configurations.

Examples of validated tools are Face-Arm-Speech-Test (FAST) or the Recognition of Stroke in the Emergency Room (ROSIER) Scale.

Symptoms are assumed to be persistent if they are still present when ambulance staff arrive at the patient's location.

Data source

Structure: Local data collection.

Process: Trusts can collect data via the Sentinel Stroke National Audit Program (SSNAP) and through local data collection.

Quality statement 2: Neuro-imaging

Quality statement

Patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.

Quality measure

Structure: Evidence of local arrangements to ensure patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.

Process: Proportion of patients with acute stroke who meet any of the indications for immediate imaging who have had brain imaging within 1 hour of arrival at the hospital.

Numerator – the number of patients who have had brain imaging within 1 hour of arrival at the hospital.

Denominator – the number of patients with acute stroke attending hospital who meet any of the indications for immediate imaging.

What the quality statement means for each audience

Service providers ensure facilities and protocols are available for patients to receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.

Healthcare professionals ensure that patients under their care with acute stroke receive brain imaging within 1 hour of arrival at the hospital if the criteria for immediate imaging are met.

Commissioners ensure that services they commission enable patients to receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.

Patients with acute stroke with any of the indications for immediate brain imaging can expect to receive this within 1 hour of arrival at the hospital.

Definitions

NICE clinical guideline 68 states that brain imaging should be performed immediately for people with acute stroke if any of the following apply:

- Indications for thrombolysis or early anticoagulation treatment (for further information, please refer to NICE technology appraisal 122 Alteplase for the treatment of acute ischaemic stroke).
- On anticoagulant treatment.
- A known bleeding tendency.
- A depressed level of consciousness (Glasgow Coma Score below 13).
- Unexplained progressive or fluctuating symptoms.
- Papilloedema, neck stiffness or fever.
- Severe headache at onset of stroke symptoms.

Data source

Structure: Local data collection.

Process: Trusts can collect data via the Sentinel Stroke Audit, Hospital Episode Statistics (HES) data and through local data collection.

Quality statement 3: Admission of patients with suspected stroke

Quality statement

Patients with suspected stroke are admitted directly to a specialist acute stroke unit and assessed for thrombolysis, receiving it if clinically indicated.

Quality measure

Structure: Evidence of local arrangements to ensure that patients with suspected stroke are admitted directly to a specialist acute stroke unit and are assessed for thrombolysis, receiving it if clinically indicated.

Process:

(a) Proportion of patients admitted directly to a specialist acute stroke unit and assessed for thrombolysis.

Numerator – the number of patients admitted directly to a specialist acute stroke unit and assessed for thrombolysis.

Denominator – the number of patients with suspected stroke admitted to hospital.

(b) Proportion of patients with suspected stroke assessed for thrombolysis who receive it in accordance with NICE technology appraisal guidance 122 (2007) and NICE clinical guideline 68 (2008).

Numerator – the number of patients who received thrombolysis in accordance with NICE technology appraisal guidance 122 (2007) and NICE clinical guideline 68 (2008).

Denominator – the number of patients with suspected stroke assessed to require thrombolysis.

What the quality statement means for each audience

Service providers ensure that patients with suspected stroke are admitted directly to a specialist acute stroke unit to be assessed for thrombolysis, receiving it if clinically indicated.

Healthcare professionals admit all patients with suspected stroke directly to a specialist acute stroke unit to be assessed for thrombolysis, which is administered if clinically indicated.

Commissioners ensure services admit all patients with suspected stroke directly to a specialist acute stroke unit to be assessed for thrombolysis, which is administered if clinically indicated.

Patients with suspected stroke can expect to be admitted directly to a specialist acute stroke unit to be assessed for thrombolysis, which is administered if clinically indicated.

Definitions

Direct admission to a specialist acute stroke unit includes those who first attended emergency departments. It is not defined as transfers from other departments such as medical assessment units or emergency admission units.

Each specialist acute stroke unit should have immediate access to:

- clinical staff specially trained in the delivery of acute medical care to stroke patients, including the diagnostic and administration procedures needed for the safe and effective delivery of thrombolysis
- nursing staff trained in the management of acute stroke, covering both its neurological and general medical aspects
- imaging and laboratory services
- specialist rehabilitation staff.

Data source

Structure: Local data collection.

Process: Trusts can collect data via Stroke Improvement Programme National Project 2009/10 (SINAP), Hospital Episode Statistics (HES) data and through local data collection.

Quality statement 4: Swallowing screening and nutrition management

Quality statement

Patients with acute stroke have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they have an ongoing management plan for the provision of adequate nutrition.

Quality measure

Structure: Evidence that arrangements are in place to ensure that all people with acute stroke have their swallowing screened and have an ongoing management plan for the provision of adequate nutrition, administered by a specially trained healthcare professional.

Process: Proportion of patients with acute stroke who have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication.

(a) Numerator – the number of patients who have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication.

Denominator – the number of patients with acute stroke admitted to hospital.

(b) Numerator – the number of patients with an ongoing management plan for the provision of adequate nutrition.

Denominator – the number of patients with acute stroke admitted to hospital.

What the quality statement means for each audience

Service providers ensure facilities and protocols are available to ensure that each patient with acute stroke has their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, and prior to the oral administration of food, fluid or medication, and that each patient has an ongoing management plan for the provision of adequate nutrition.

Healthcare professionals are trained to screen the swallowing of patients with acute stroke within 4 hours of admission before being given any oral food, fluid or medication, and that they implement ongoing management plans for the provision of adequate nutrition.

Commissioners ensure that services are in place for patients with acute stroke to have their swallowing screened by a specially trained healthcare professional within 4 hours of admission, prior to the oral administration of food, fluid or medication, and for the implementation of an ongoing management plan for the provision of adequate nutrition.

Patients admitted with acute stroke can expect to have their swallowing screened by a specially trained healthcare professional within 4 hours of admission, before being given any food, drink or medication by mouth, and also to have an ongoing management plan for the provision of adequate nutrition.

Definitions

Professionals trained to perform a swallow screen include nurses, doctors, and speech and language therapists.

Data source

Structure: Local data collection.

Process: Trusts can collect data via the Sentinel Stroke National Audit Program (SSNAP), SINAP, Hospital Episode Statistics (HES) data and through local data collection.

Quality statement 5: Assessment and management of patients with stroke

Quality statement

Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days.

Quality measure

Structure: Evidence of local arrangements to ensure that services are commissioned to provide patients with stroke with prompt access to specialist rehabilitation services.

Process:

(a) Proportion of patients with stroke assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital.

Numerator – the number of patients assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital.

Denominator – the number of patients with a new stroke episode admitted to hospital.

(b) Proportion of patients with stroke assessed and managed by all relevant members of the specialist rehabilitation team within 72 hours of admission to hospital.

Numerator – the number of patients assessed and managed by all relevant members of the specialist rehabilitation team within 72 hours of admission to hospital.

Denominator – the number of patients with a new stroke episode admitted to hospital.

(c) Proportion of patients with stroke with documented multidisciplinary goals agreed within 5 days of admission to hospital.

Numerator – the number of patients with documented multidisciplinary goals agreed within 5 days of admission to hospital.

Denominator – the number of patients with a new stroke episode admitted to hospital.

What the quality statement means for each audience

Service providers ensure protocols are in place so that patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days of admission to hospital.

Health and social care professionals ensure that patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days of admission to hospital.

Commissioners ensure that services are in place so that patients with stroke can be assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days of admission to hospital.

Patients with stroke can expect to be assessed and managed by stroke nursing staff and by at least one member of the specialist rehabilitation team within 24 hours of admission to hospital, and by all relevant members of the specialist rehabilitation team within 72 hours, with documented multidisciplinary goals agreed within 5 days of admission to hospital.

Definitions

Given the range of problems faced by patients with stroke, the core of the specialist rehabilitation team will include physiotherapy, occupational therapy, speech and language therapy, and psychology. Support and input from social work, dietetics, pharmacy, orthotics and orthoptics should be available as required to address patients' needs.

Data source

Structure: Local data collection.

Process: Trusts can collect data via the Sentinel Stroke National Audit Program (SSNAP), SINAP, Hospital Episode Statistics (HES) data and through local data collection.

Quality statement 6: Ongoing inpatient rehabilitation

Quality statement

Patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment are treated in a specialist stroke rehabilitation unit.

Quality measure

Structure: Evidence of local arrangements to ensure all patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment are treated in a specialist stroke rehabilitation unit.

Process: Proportion of patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment who are treated in a specialist stroke rehabilitation unit.

Numerator – the number of patients who are treated in a specialist stroke rehabilitation unit.

Denominator – the number of patients who need ongoing specialist stroke rehabilitation after completion of their acute diagnosis and treatment.

What the quality statement means for each audience

Service providers ensure all patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment are treated in a specialist stroke rehabilitation unit.

Healthcare professionals treat patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment in a specialist stroke rehabilitation unit.

Commissioners ensure that specialist stroke rehabilitation units are commissioned to treat patients who need inpatient rehabilitation after completion of their acute diagnosis and treatment.

Patients who need ongoing inpatient rehabilitation after completion of their acute diagnosis and treatment can expect to be treated in a specialist stroke rehabilitation unit.

Definitions

A specialist stroke rehabilitation unit should meet all of the following criteria:

- It should be a discrete unit within the hospital.
- It should have a coordinated multidisciplinary team that meets at least once a week to exchange information about patients.
- Staff should have specialist expertise in stroke and rehabilitation.
- Educational programmes and information should be provided for staff, patients and carers.

Data source

Structure: Local data collection.

Process: Trusts can collect data via the Sentinel Stroke National Audit Program (SSNAP) and through local data collection.

Quality statement 7: Ongoing rehabilitation

Quality statement

Patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it.

Quality measure

Structure: Evidence that local arrangements are in place for the provision of a minimum of 45 minutes of each active therapy for a minimum of 5 days a week that enables patients with stroke to meet their rehabilitation goals.

Process: Proportion of patients with stroke who are offered 45 minutes of each active therapy that is required, for as long as they are continuing to benefit from the therapy and are able to tolerate it.

Numerator – the number of patients who are offered a minimum of 45 minutes of each active therapy for a minimum of 5 days a week.

Denominator – the number of patients with a new stroke episode in hospital.

What the quality statement means for each audience

Service providers ensure that there are agreed local policies and protocols to offer patients with stroke a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days each week, that enables them to meet their rehabilitation goals for as long as they continue to benefit from the therapy and are able to tolerate it.

Healthcare professionals offer patients with stroke a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, to enable them to meet their rehabilitation goals, for as long as they continue to benefit from the therapy and are able to tolerate it.

Commissioners ensure that active therapy services are available to offer patients with stroke a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days each week, that enables them to meet their rehabilitation goals for as long as they continue to benefit from the therapy and are able to tolerate it.

Patients with stroke can expect to be offered at least 45 minutes of each active therapy, for a minimum of 5 times each week, to enable them to meet their rehabilitation goals, as long as they are continuing to benefit from it and are able to tolerate it.

Definitions

Therapy services are defined as physiotherapy, occupational therapy, and speech and language therapy. Individual patients may require treatment from other professionals such as psychology and dietetics.

Active therapy is defined as face-to face-contact, which may be individual or group treatment, and may include tele-therapy. It does not include administrative tasks related to patients.

Tolerate is defined as having sufficient physical and mental capacity to be able to participate in the treatment, and individual patients consenting to treatment.

Continue to benefit is defined as showing evidence on objective assessment of improving over time.

This standard applies to therapy delivered in both hospital and community settings.

Data source

Structure: Local data collection.

Process: Trusts can collect data via Hospital Episode Statistics (HES) data and through local data collection.

Quality statement 8: Continence management

Quality statement

Patients with stroke who have continued loss of bladder control 2 weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers.

Quality measure

Structure: Evidence of local arrangements to ensure that patients with loss of bladder control at 2 weeks are reassessed and have treatment plans implemented involving both patients and carers.

Process: The proportion of patients with loss of bladder control at 2 weeks who were reassessed to identify the cause, and had a treatment plan implemented involving patients and carers.

(a) Numerator – the number of patients reassessed to identify the cause.

Denominator – the number of stroke patients with loss of bladder control at 2 weeks.

(b) Numerator – the number of patients with a treatment plan involving both patients and carers.

Denominator – the number of patients with stroke who have loss of bladder control at 2 weeks.

What the quality statement means for each audience

Service providers ensure that all patients with loss of bladder control at 2 weeks are reassessed to identify the cause and have treatment plans implemented, involving both patients and carers.

Health and social care professionals ensure that all patients with loss of bladder control at 2 weeks are reassessed to identify the cause and have a treatment plan implemented, involving both patients and carers.

Commissioners ensure that services are in place to ensure that service providers reassess and treat all patients with loss of bladder control at 2 weeks appropriately.

Patients with loss of bladder control at 2 weeks can expect to be reassessed to identify the cause, and have a treatment plan implemented involving both patients and carers.

Definitions

Patients with stroke who have continued loss of bladder control 2 weeks from diagnosis should only be discharged home with continuing incontinence after carers (family members) or patients are fully trained and adequate arrangements for social services and a continuing supply of continence aids are confirmed and in place.

Data source

Structure: Local data collection.

Process: Local data collection. Trusts can collect data via the Sentinel Stroke National Audit Program (SSNAP) and local data collection.

Quality statement 9: Mood disturbance and cognitive impairments

Quality statement

All patients after stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment.

Quality measure

Structure: Evidence that patients with stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment.

Process: Proportion of patients with stroke who have been screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment.

(a) Numerator – the number of patients with stroke screened for mood disturbance using a validated screening tool within 6 weeks of a diagnosis of stroke.

Denominator – the number of patients diagnosed with a new episode of stroke.

(b) Numerator – the number of patients with stroke who have been screened for cognitive impairment within 6 weeks of diagnosis.

Denominator – the number of patients diagnosed with a new episode of stroke.

What the quality statement means for each audience

Service providers ensure that there are agreed local policies and guidelines for screening patients with stroke within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment.

Healthcare professionals ensure patients with stroke are screened for mood disturbance and cognitive impairments using a validated screening tool within 6 weeks of diagnosis.

Commissioners ensure that services are in place to enable the screening of all stroke patients for mood disturbance and cognitive impairments using a validated screening tool within 6 weeks of diagnosis.

Patients with stroke can expect to be screened for mood disturbance and cognitive impairments using a validated screening tool within 6 weeks of diagnosis.

Definitions

This standard applies in both hospital and community settings. Administration of the screening tools should be conducted by trained staff.

When using validated tools to identify mood disturbance or cognitive impairments, healthcare professionals should be mindful of the need to secure equality of access to treatment for patients from different ethnic groups (in particular those from different cultural backgrounds) and patients with disabilities.

Data source

Structure: Local data collection.

Process: Local data collection. Trusts can collect data via the Sentinel Stroke National Audit Program (SSNAP), SINAP and local data collection.

Quality statement 10: Ongoing outpatient rehabilitation assessment

Quality statement

All patients discharged from hospital who have residual stroke-related problems are followed-up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.

Quality measure

Structure: Evidence of local arrangements to ensure patients discharged from hospital who have residual stroke-related problems are followed-up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.

Process: Proportion of patients discharged from hospital with residual stroke-related problems who are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.

Numerator – the number of patients followed-up by specialist stroke rehabilitation services for assessment and ongoing management within 72 hours of discharge from hospital.

Denominator – the number of patients discharged from hospital with residual stroke-related problems.

What the quality statement means for each audience

Service providers ensure that all patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.

Healthcare professionals ensure that patients with residual stroke-related problems are followed up by specialist stroke rehabilitation services within 72 hours for assessment and ongoing management.

Commissioners ensure that specialist stroke rehabilitation services are available so that all patients discharged from hospital who have residual stroke-related problems are followed up within 72 hours.

Patients with residual stroke-related problems can expect to be followed up by stroke specialist rehabilitation services for assessment and ongoing management within 72 hours of their discharge from hospital.

Definitions

Residual problems can include physical problems, loss of cognitive or communication skills, anxiety, depression or other psychological problems.

Data source

Structure: Local data collection.

Process: Local data collection. Trusts can collect data via Hospital Episode Statistics (HES) data, the Sentinel Stroke National Audit Program (SSNAP) and through local data collection.

Quality statement 11: Carer provisions

Quality statement

Carers of patients with stroke have: a named contact for stroke information; written information about patient's diagnosis and management plan; and sufficient practical training to enable them to provide care.

Quality measure

Structure:

(a) Evidence of local arrangements to ensure that carers of patients with stroke have: a named contact for stroke information; written information about patient's diagnosis and management plan; and sufficient practical training to enable them to provide care.

(b) Evidence that a carer's experience survey has been completed.

Process: Proportion of patients with stroke whose carers have: a named contact for stroke information; written information about patient's diagnosis and management plan; and sufficient practical training to enable them to provide care.

Numerator – the number of carers who have:

(a) a named contact for stroke information

(b) written information about the patient's diagnosis and management plan

(c) sufficient practical training to provide care.

Denominator – the number of carers of patients with stroke.

What the quality statement means for each audience

Service providers ensure that local policies are in place to ensure that the carers of all patients with stroke have: a named contact for stroke information; written information about the patient's diagnosis and management plan; and sufficient practical training to enable them to provide care. They obtain the carer's opinion through a carer's experience survey.

Health and social care professionals ensure that carers of all patients with stroke have: a named contact for stroke information; written information about the patient's diagnosis and management plan; and sufficient practical training to enable them to provide care.

Commissioners ensure that services are in place to enable carers of every patient with stroke to have: a named contact for stroke information; written information about the patient's diagnosis and management plan; and sufficient practical training to enable them to provide care. Commissioners ensure that service providers obtain the carer's opinion through a carer's experience survey.

Carers have: a named contact for stroke information; written information about the patient's diagnosis and management plan; and sufficient practical training to enable them to provide care. The carer's opinion will be obtained through a carer's experience survey

Definitions

Written information for patients can be found in the RCP booklet Care after stroke or transient ischaemic attack (2008). Information about NICE guidance, written specifically for patients can be found in Stroke: understanding NICE guidance NICE clinical guideline 68 (2008).

Data source

Structure: Local data collection.

Process: Local data collection using a carer survey.

Commissioning for Quality and Innovation (2010/2011) Patient Experience Goal 2:

Improve response to personal needs of patients.

Each describes a different element of the overarching theme – response to personal needs:

- Involvement in decisions about treatment and care.
- Hospital staff are available to talk about worries or concerns.
- Privacy when discussing the condition or treatment.
- Information about medication side-effects.

- Information about who to contact if worried about the condition after leaving hospital.

Using the quality standard

It is important that the quality standard is considered alongside current policy and guidance documents listed in the development sources section.

Commissioning support and information for patients

NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard. A full guide for commissioners on the diagnosis and initial management of acute stroke is also available. Information for patients using the quality standard is also available on the NICE website.

Quality measures and national indicators

The quality measures accompanying the quality standard aim to improve the structure, process and outcomes of healthcare. They are not a new set of targets or mandatory indicators for performance management.

Expected levels of achievement for quality measures are not specified. As quality standards are intended to drive up the quality of care, achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, we recognise that this may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.

We have indicated where national indicators currently exist and measure the quality statement. National indicators include those developed by the Health and Social Care Information Centre through their Indicators for Quality Improvement Programme. For statements where national quality indicators do not exist, the quality measures should form the basis for audit criteria developed and used locally to improve the quality of healthcare.

For further information, including guidance on using quality measures, please see What makes up a NICE quality standard.

Diversity, equality and language

During the development of this quality standard, equality issues were considered.

Good communication between health and social care professionals and patients with stroke is essential. Treatment and care, and the information given about it, should be culturally appropriate. It should also be accessible to patients with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Patients with stroke should have access to an interpreter or advocate if needed.

Development sources

Evidence sources

The document below contains clinical guideline recommendations or other recommendations that were used by the TEG to develop the quality standard statements and measures.

Royal College of Physicians (2008) National clinical guideline for stroke, which incorporates Diagnosis and initial management of acute stroke and transient ischaemic attack. NICE clinical guideline 68 (2008).

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

Department of Health (2007) National Stroke Strategy.

National Audit Office (2010) Department of Health: Progress in improving stroke care.

National Audit Office (2005) Department of Health: Reducing brain damage: faster access to better stroke care.

Related NICE quality standards

Patient experience in adult NHS services. NICE quality standard 15 (2012).

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About this quality standard

NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective patient care, covering the treatment and prevention of different diseases and conditions. Derived from the best available evidence such as NICE guidance and other evidence sources accredited by NHS Evidence, they are developed independently by NICE, in collaboration with NHS and social care professionals, their partners and service users, and address three dimensions of quality: clinical effectiveness, patient safety and patient experience.

The methods and processes for developing NICE quality standards are described in the healthcare quality standards process guide.

This quality standard has been incorporated into the NICE stroke pathway.

We have produced a summary for patients and carers.

Changes after publication

November 2015: minor maintenance.

April 2015: minor maintenance.

August 2013: minor maintenance.

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Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of Physicians
- Stroke Improvement Programme
- Social Care Institute for Excellence
- Stroke Association