

# **STROKE SERVICE**

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## **Service Specification (example)**

**This specification gives a broad overview of a stroke service and how it may link into other CCDHB services.**

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## **1. Introduction**

The aim of this service specification is to implement organised stroke care, assist best practice through use of the stroke guidelines, and improve outcomes for people with stroke and transient ischaemic attack (TIA). This Service Specification for Stroke covers the management of patients with stroke from onset through rehabilitation, both inpatient and community based.

The impact of stroke in New Zealand is significant. It is the third leading cause of death and the greatest cause of disability in older people. Reducing the incidence and impact of cardiovascular disease is one of the thirteen New Zealand Health Strategy immediate action priority objectives for population health.

There is increasing evidence to support the development of organised stroke services in New Zealand. Organised stroke services provide the benefits of early assessment and timely intervention and have been proven beyond doubt to reduce both morbidity and mortality following stroke. The benefits apply to all patients regardless of age, stroke severity or co-morbidities and are sustained for at least 5-10 years. The service components of organised stroke care consist of a geographically identified unit, a co-ordinated multidisciplinary team, staff with specialist expertise in stroke and rehabilitation, educational programmes for staff, patients and carers, and agreed protocols for common problems.

Efficient and effective management of patients depends upon a well-organised, expert service that can respond to the particular needs of each individual patient. Consequently, the organisation of stroke services and care of patients must be considered at every level of service delivery provision by District Health Boards (DHBs) including:

- primary care
- access to investigations
- hospital
- community services (including both rehabilitation and support services)
- Liaison with volunteer organisations (e.g Stroke Foundation)

This Tier 2 Service Specification for Stroke Services is linked to the Tier 1 overarching service specification for Specialist General Medical and General Surgical Services. Please refer to the tier one specification for additional information on:

- Service Objectives (General and Māori Health)
- Service Users
- Access (including entry and exit criteria and time)
- General Service Components (including key inputs, settings, facilities, support services and processes)
- Service Linkages
- Exclusions

- **Quality Requirements**

## 2. Definition

This service specification is applicable to stroke services, including services for people with TIA.

Stroke is defined by the World Health Organisation as a condition characterised by rapidly developing symptoms and signs of a focal brain lesion, with symptoms lasting more than 24 hours or leading to death, with no apparent cause other than that of vascular origin. Transient ischaemic attacks (TIAs) are defined as where these symptoms and signs last less than 24 hours. TIAs share the same causes as stroke and may precede a stroke. (WHO MONICA Project 1988) This service specification includes rehabilitation of people with stroke due to SAH (Sub Arachnoid Haemorrhage) but does not include the neurosurgical management of SAH.

### Service Objectives

#### *General*

This service specification should also be read in conjunction with the service specification for Tier 2 General Medicine and AT&R service specifications and the New Zealand Stroke guidelines. The New Zealand Guidelines Group (NZGG) Stroke Guidelines (NZ Stroke Guidelines) provide more detailed information on the care of patients with stroke.

#### *Māori Health*

The Treaty of Waitangi establishes the unique and special relationship between Iwi, Māori, and the Crown. As a Crown agency, the Ministry of Health considers the Treaty of Waitangi's principles of partnership, proactive protection of Māori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the Ministry of Health responds to Māori health issues.

The DHB is required to recognise Māori health as a health gain priority area and is therefore expected to establish and implement a Māori health policy that reflects this. In developing this policy, the DHB must take into account the Ministry of Health's strategic direction for Māori health. The DHB will provide stroke services in a way that contributes to the objectives of He Korowai Oranga - the Māori Health Strategy. In particular, the DHB should aim to increase access to high quality and effective health and disability services that improve Māori health, and to work towards removing inequalities in Māori health status.

Stroke is a health gain priority area for Māori. Prevalence, morbidity, and mortality rates from stroke are all higher in Māori than in people of European origin. Healthcare providers must recognise the cultural values and beliefs

that influence the effectiveness of services for Māori people with stroke, and must consult and include Māori in service design and delivery.

The DHB will develop their Māori implementation plan within 3 months of the implementation of this service specification.

### *Pacific Peoples*

The Pacific Health and Disability Action Plan was released in February, 2002. It sets strategic direction and means of improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples. The Plan emphasizes the importance of cultural values and beliefs as a determinant of health. This is particularly important for Pacific communities with cultural diversities, different languages, protocols, beliefs and traditions, and a mixture of Island-born and NZ-born peoples.

With a higher prevalence of stroke compared to the general population, healthcare providers must be aware that the effectiveness of services to Pacific peoples with stroke can only be enhanced by recognising their cultural values and beliefs and by utilising and supporting their local Pacific community health organisation/workers.

The DHB will use the Pacific Health and Disability Action Plan to work and consult with its local Pacific community in designing the best services needed for their Pacific stroke patients and how it will be best implemented. This includes ensuring access to high quality and effective health and disability services that improve Pacific health and reduce inequalities.

### **3. Service Users**

All adult patients regardless of age presenting with suspected diagnosis of stroke and TIA. Although largely a disease of older people 25% of strokes occur in people aged less than 65 years and 5% in people aged 45 years or less.

## Entry Criteria

All patients with a definite or presumptive diagnosis of a new stroke or TIA should be admitted to hospital unless:

- Their symptoms have fully recovered or are rapidly recovering so that there is likely to be no or minimal interference in activities of daily living within a short period of days AND
- They live with a competent carer nominated by the person with stroke who is available to provide care or are able to recover home alone AND
- Diagnostic and secondary prevention issues can be addressed promptly by or in discussion with specialist stroke services (*promptly implies 100% assessed within 7- 14 days*) AND
- There is a formal arrangement with primary care health practitioner AND
- Any required initial input from specialist rehabilitation and support services (such as DHB home help and personal care) can be instituted immediately (*immediately implies same day for support and next day for rehabilitation services*) unless minimal residual deficit only.

OR

- In the opinion of the treating doctor AND the person with stroke/family of the person with stroke, no benefit to the person is likely through admission to hospital. This might apply in situations, for example, where the person was already substantially disabled or suffering from a terminal illness.

OR

- Despite a full understanding of the benefits of admission to hospital, the person with stroke and their family may decide to have care at home. In this situation all patients should be offered and have access to specialist review and investigations, as well as community rehabilitation and support services (such as home help and personal care) which should be instituted immediately (*immediately implies same day for initial support, next day for rehabilitation services*).

## Exit Criteria

- Completed assessment confirms the patient does not have a stroke
- Full recovery with all diagnostic and secondary prevention issues addressed
- Rehabilitation (inpatient and/or outpatient) has achieved maximum mutually agreed goals.
- Person with stroke declines further treatment

## Time

Speed of admission to hospital, stroke is a medical emergency and all patients should be transferred to hospital as a matter of urgency.

Access to specialist medical advice and assistance is available 24 hours a day and access to specialist outpatient review is available within 7-14 days.

**Initial access to community support is available same day (within working hours) and rehabilitation services are available within 24 hours (Monday to Friday)**

**Timely access to investigations including brain imaging and duplex ultrasound (within 5 working days)**

## **4. Service Components**

### **Processes**

#### **Organised stroke services**

**There is now overwhelming evidence that the single most important intervention that would improve outcomes for all people with stroke is the provision of organised stroke services. The organisation of stroke services, as set out below, would likely result in compliance with many of the specific recommendations for “best practice” in stroke care and improve the overall outcomes.**

**The management of the individual by stroke services involves a complex sequence of relationships and events. The level of intervention will depend on the condition of the individual, their consent for treatment, the qualifications, training and experience of the clinical staff and the level of clinical support available. Services provided should include:**

- **Clustering of consumers in flexible inpatient bedded areas with sufficient capacity to manage most patients admitted to hospital with stroke acting as a base**
- **Lead clinician of the service**
- **A co-ordinated multidisciplinary team**
- **Staff with specialist expertise in stroke and rehabilitation**
- **Education programmes for staff, patients and carers**
- **Agreed protocols for common problems**
- **An outpatient neurovascular service or clinic for the rapid assessment of transient ischaemic attack and minor stroke**
- **Timely access to brain and vascular imaging services**
- **For patients not admitted to hospital timely assessment, investigation and on-going treatment/management in the community.**
- **Integration of all the above service components including primary and secondary services for stroke**
- **Community based rehabilitation and support services**

SERVICE COMPONENT	DESCRIPTION
<p><b>Diagnosis and Assessment of TIA</b></p>	<p><b>Prompt clinical assessment - including investigations within 7-14 days of TIA event</b>  <b>Antiplatelet therapy commenced while waiting for assessment</b>  <b>If neurological symptoms persist for more than one hour without improvement the patient should be managed as if a stroke has occurred.</b>  <b>Patients who have had a ‘flurry’ of TIAs over a few hours or days should be urgently admitted to hospital</b>  <b>Imaging with CT or magnetic resonance is recommended for all patients after a hemispheric TIA especially if TIAs are recurrent and stereotyped</b></p>
<p><b>Diagnosis of stroke</b></p>	<p><b>Stroke is primarily a clinical diagnosis</b>  <b>Clinical diagnosis and imaging should always be reviewed by a physician with special expertise in stroke</b>  <b>The patients cardiovascular status must be reviewed (as per NZ stroke guidelines)</b>  <b>A CT scan or MRI scan should be carried out as soon as possible and no later than 24-48 hours to confirm the diagnosis of stroke, differentiate ischaemic stroke from intracerebral haemorrhage and to rule out other illnesses</b>  <b>The CT or MRI scan should be carried out before antiplatelet agents or anticoagulants are administered</b></p>
<p><b>Acute phase</b></p>	<p><b>All stroke patients are the responsibility of and are managed by services specialising in stroke and rehabilitation. This includes a lead stroke clinician and multidisciplinary team (MDT).</b>  <b>The MDT consists of staff who have specialist experience in stroke and rehabilitation working in a dedicated facility/area</b></p>
<p><b>Assessment and treatment</b></p>	<p><b>Stroke services will be responsible for the complete and coordinated assessment, diagnosis, referral, treatment, and on-going management of people with stroke throughout the course of that chronic condition.</b>  <b>Treatment will span the range from primary to tertiary care including support services</b>  <b>Appropriately trained, qualified and experienced clinical and support personnel, appropriate services and facilities are required to ensure timely and definitive care</b>  <b>A level of preparedness must be maintained at secondary level to receive all appropriate acute referrals on a 24-hour basis</b></p>
<p><b>Rehabilitation</b></p>	<p><b>The service should integrate the key principles of rehabilitation into each aspect of the stroke service. These principles include:</b></p>

SERVICE COMPONENT	DESCRIPTION
	<p>Supervision by an expert MDT            Early activation and mobilisation            Early involvement of the family and carer            Focus on mutually agreed goals            A task and context specific approach            Provision for practice and repetition, together with patient self learning            Goals aimed at maximising activity and participation back in the community            Rehabilitation should occur in the most appropriate context for the stroke person. This means there should be availability for inpatient and community based rehabilitation programmes that are specific for stroke</p>
<p><b>Routine Early Assessments</b></p>	<p>Early <u>routine</u> assessment in the following specific areas as part of the overall assessment of the stroke person:            Level of consciousness            Swallowing            Moving/handling            Nutrition            Communication            Self-care            Risk of developing pressure areas            Mood            Risk of falling            Suitability of likely discharge accommodation            Early discharge planning            Available supports on discharge</p> <p>The need to repeat assessments (and timing of repeat assessments) will depend on whether a problem is identified and its significance in the overall planning for a particular patient.</p>
<p><b>Relationship of family /patient</b></p>	<p>Involvement of the patient and their family/whānau (the patient's nominated family support) are central to recovery from stroke. Services need to include the following:            Provision of information including answers to questions in a manner appropriate for the person with stroke and their family/whanau ( or the patient's nominated support).            Involvement of the person with stroke and their family/whanau (or the patient's nominated support) in decision making            Family (the patient's nominated family support) /Carer fully informed of the extent of condition/prognosis and the ongoing implications of caring for patient.            Patient informed of all options of care other than family and what the implications are of the alternatives.            Agreement of the patient that this is the family member/carer</p>

SERVICE COMPONENT	DESCRIPTION
	<p>they would like to care for them. Patient and family aware of availability of assistance/counselling for changes/ other social assistance due to changes in lifestyle. (WINZ, Legal, etc) A contact person (outside family) who can assist with issues in a confidential manner for the patient. Financial strain or issues for both the patient and the carers are addressed</p>
<p><b>Assessment pre-discharge</b></p>	<p>As per the Stroke Guidelines: Major interests of the stroke person Long term goals of the person with stroke Work/study/leisure situation Ensure the person with stroke is involved in the decision making Advice on driving (LTSA recommendations)</p>
<p><b>Identification of risk factors</b></p>	<p>Following the completion of investigations all patients will be given a written list of risk factors and a management plan directed at reducing recurrence of stroke.</p>
<p><b>Early supported discharge</b></p>	<p>An early supported discharge service should be available for selected patients provided a full community support service is available for them and they continue to be seen by a multidisciplinary stroke team.</p>
<p><b>Assessment once the person is back in the community (in some instances may be done in conjunction with another agency or provider or separate service)</b></p>	<p>Appropriate assessment once the person is (back) in the community will depend to a large extent on any problems identified by the person and their family/carers. There must be close collaboration at individual patient and service levels to provide integrated continuous service. Consideration should be given to assessment of: Long term goals of the stroke person Ability to perform basic and extended activities of daily living Amount of help (formal and informal) required to perform everyday activities Mood and other psychological issues Sexuality Carer stress</p>
<p><b>Organisation of community services</b></p>	<p>Specialist day hospital rehabilitation or specialist domiciliary rehabilitation should be offered to stroke outpatients. Evidence shows that both have equal clinical outcomes</p>
<p><b>Health, particularly mood, of main carer(s)</b></p>	<p>Families/carers are supported by: Information on the nature of stroke, its manifestations and relevant local and national services available to support stroke people, and their carers and families</p>

<b>SERVICE COMPONENT</b>	<b>DESCRIPTION</b>
	<p><b>Stress relief for carers. Family/carer support workers should be involved to help reduce carer distress</b></p> <p><b>Reduction of stress on family and carers of people with stroke. Stroke services must be alert to the likely stress on family and carers associated with ‘hidden’ impairments such as cognitive loss, urinary incontinence, and irritability</b></p> <p><b>Regular review of psychosocial &amp; support needs</b></p> <p><b>Families and carers are to be involved in decision-making and the formulation of plans where appropriate.</b></p> <p><b>The need for younger family members, ie; children of stroke person to have access to counselling when appropriate (regardless of how long after the event).</b></p>

### Service Level/Settings and Key Inputs

The service levels identified in Sections below attempt to combine the known evidence for effectiveness with practical considerations. These are minimum requirements so where local circumstances or staffing levels allow, hospitals should aim for a higher level of service.

<b>Organised Stroke Services Key Components</b>	<b>Large DHB (pop. &gt;180,00)</b>	<b>Medium DHB</b>	<b>Small DHB (pop &gt;80,000)</b>
<b>Lead Physician</b>	a nominated physician for leadership, planning, implementation, and accountability for best practice management of people with stroke.	a nominated physician for leadership, planning, implementation, and accountability for best practice management of people with stroke.	a nominated physician for leadership, planning, implementation, and accountability for best practice management of people with stroke.
<b>Level of Stroke expertise for clinical overview of patients</b>	Stroke expert physician responsible for all patients with stroke	Stroke expert physician in the team caring for patients	Stroke expert physician in the team caring for patients
<b>Location and type of stroke inpatient care/facility – Acute Care Beds</b>	Either in a combined acute & rehabilitation stroke unit or an acute stroke unit	Either an acute stroke unit or aggregation of stroke patients in a general ward	Aggregation of stroke patients in a general ward
<b>Location and type of stroke inpatient care/facility – Rehabilitation Beds</b>	Either in a combined acute & rehabilitation stroke unit or a rehabilitation stroke unit	Either a rehabilitation stroke unit or aggregation of patients in an AT&R ward	Aggregation of patients in an AT&R ward
<b>Inpatient Multi Disciplinary Team (MDT) expertise and specialization in stroke and rehabilitation</b>	A MDT with expertise in stroke and rehabilitation, dedicated to stroke	A MDT with expertise in stroke and rehabilitation but not dedicated solely to stroke	A MDT with expertise in rehabilitation

<b>Community Rehabilitation service</b>	<b>close links should exist between inpatient and community rehabilitation services</b>		
	<b>A dedicated community MDT with expertise in stroke and rehabilitation. Some team members may be “stroke dedicated” (eg nurse) while others may have an additional non-stroke caseload (eg physician, Speech Language Therapist)</b>	<b>A community MDT with expertise in rehabilitation and the management of stroke. It is expected that all team members would have an interest and expertise in stroke, but it is likely they will also have an additional non-stroke caseload.</b>	<b>A community MDT with expertise in rehabilitation. These professionals should also have close linkages with “stroke specific’ community rehabilitation teams within larger DHBs to enhance their stroke expertise.</b>
<b>Neurovascular or Outpatient Services</b>	<b>diagnosis and secondary prevention issues in those patients with minor stroke or transient ischaemic attack in the community or not admitted to hospital. Patients should have access to specialist advice, outpatient assessment and investigations within 7-14 days.</b>		
	<b>This assessment should be via a specialised neurovascular clinic or service.</b>	<b>This assessment should ideally be via a specialised neurovascular clinic or service but may occur via other specialist clinics and services.</b>	<b>This assessment could be via a specialised neurovascular clinic but is likely to be provided via other specialist clinics</b>

## **Equipment**

**This includes the supply and/or loan of equipment, equipment medical supplies and consumables necessary to support care where covered.**

## **Support services**

**These include but are not limited to:**

- **Diagnostic imaging including MRI, CT scan, ultrasound, fluoroscopy**
- **Pathology including tests referred to community laboratories**
- **Supplies and equipment including prostheses, contact lenses, hearing aids, artificial limbs, wheelchairs and other equipment**
- **Sterile supply**
- **Pharmacy**

**These services may be provided through hospitals or in other settings as deemed most appropriate.**

## **Facilities**

**All patients admitted to hospital with stroke should expect to be managed in an area of the hospital designated for patients with stroke (i.e. a stroke unit or designated beds), which is physically appropriate for people with disability and has sufficient skilled staff. The patient's care should be the responsibility of a nominated stroke clinician(s).**

## Service Linkages

The main groupings of service providers involved in the delivery of Stroke services.

Group	Organisations/Providers	Nature of Linkages	Accountabilities associated with linkage
<b>Primary care (general practice teams)</b>	<b>Primary HealthCare Organisation</b> <b>Specialist nursing services including, but not limited to:</b> <b>Primary Healthcare Nurses,</b> <b>Specialist Professional Community Nursing Services,</b> <b>Nurse Specialists,</b> <b>Cardiovascular Disease Nurse Educators, Diabetes Nurses and Educators and Mobile Māori Disease-State Management Nurses</b> <b>Community support providers</b>	<b>Achieve a continuum of care</b>	<b>Responsible for providing follow up care and continuity of care by providing appropriate referrals to secondary services and implementing discharge plans for stroke patients.</b>
<b>Specialist services providing stroke services</b>	<b>Nursing specialists</b> <b>Other specialists providing stroke consultation</b> <b>Tertiary services</b> <b>Geriatric and AT&amp;R services</b> <b>Mental health services</b> <b>Radiology, laboratory services</b> <b>Emergency services including ED</b> <b>Neuro-psychological services</b> <b>Counselling services</b>	<b>Expertise in these specialty services are as an input into or are a component of organised stroke care within hospital services</b>	<b>Provision of Specialist Care</b>

	<b>General Medical and Neurological services</b>		
<b>Rural Services</b>	<b>All rural hospital and community services</b>	<b>Availability of health services in remote locations that support achievement of a continuum of care</b>	<b>Supported rehabilitation services, including using existing local professionals Rapid transfer to base hospital for acute treatments Liaison with Stroke specific clinicians (both hospital and community based)</b>
<b>Māori and Providers</b>	<b>Māori Primary Health Organisations Māori Community Health Services Mobile Māori disease management services</b>	<b>Achieve a culturally appropriate continuum of care</b>	<b>Provision of culturally appropriate care and co-ordination with mainstream providers</b>
<b>Pacific Providers</b>	<b>Pacific Primary Health Organisations and health professional specialist staff</b>	<b>Achieve a culturally appropriate continuum of care</b>	<b>Provision of culturally appropriate care and co-ordination with mainstream providers to ensure continuity of care</b>
<b>Disability Support Services</b>	<b>Community support carer support, residential care Services for younger people with disability</b>	<b>Support for patients, their families and carers in their community settings</b>	<b>Provision of community support in the home and longer term care</b>
<b>Social</b>	<b>Work and Income</b>	<b>Availability of and access to appropriate</b>	<b>Provision of social support</b>

<b>services</b>	<b>Social worker services</b>	<b>social services for patients</b>	
<b>Voluntary services</b>	<b>Stroke Foundation of New Zealand e.g. Stroke Foundation field officers Age Concern</b>	<b>Availability of and access to appropriate volunteer services for patients</b>	<b>Support for individuals</b>
<b>Emergency Services</b>	<b>Ambulance Services Hospital Emergency Departments</b>	<b>Availability of emergency care and rapid response services</b>	<b>Rapid assessment and diagnosis of stroke</b>

<p><b>Care Coordination Centre (CCC)</b></p>		<p><b>Manage referrals liaise and work with these services to coordinate the care plan and ensure a seamless continuum of care for the consumer.</b></p>	<p><b>CCC is responsible for forwarding/generating referrals to the Stroke service in a timely manner with appropriate information.</b></p> <p><b>The Stroke service is responsible for acknowledging and responding to referrals from the CCC.</b></p> <p><b>The Stroke service is responsible for lodging summaries of relevant assessment and care plans with the CCC.</b></p> <p><b>The CCC is responsible for receiving and storing summaries of relevant assessment and care plans from The Stroke service.</b></p> <p><b>The CCC is responsible for coordinating the care plan to ensure the consumer receives the care in a timely and appropriate manner.</b></p> <p><b>The Stroke service is responsible for ensuring updates of assessment and care plans are communicated to the CCC</b></p> <p><b>The CCC is responsible for ensuring that updates of assessment and care plans are stored and coordinated following any monitoring and review of care plans.</b></p> <p><b>The Stroke service is responsible for informing the CCC when discharge from the The Stroke service is appropriate and ensuring that all relevant details for on going care are specified for the CCC to action.</b></p> <p><b>The CCC is responsible for receiving discharge notification from The Stroke service and storing discharge information on the consumer's file.</b></p> <p><b>The Centre is responsible for establishing services for discharge and ensuring that the ongoing oversight of the consumer's health status is transferred to their PHO/lead primary carer.</b></p>
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<p><b>Care Manager Service</b></p>		<p>Manage referrals liaise and work with these services to coordinate the care plan and ensure a seamless continuum of care for the consumer.</p>	<p>Care Managers are responsible for referring appropriate consumers to the Stroke Service via the CCC and communicating appropriate information on referral in a timely manner.</p> <p>The Stroke service and Care Managers are responsible for liasing with each other regarding outcomes of assessment, care plans, ongoing care and providing advice as required to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p>
<p><b>Specialist Health Service For Older People SHSOP</b></p>		<p>Liaise and work with SHSOP services to coordinate the care plan and ensure a seamless continuum of care for the consumer.</p>	<p>The Stroke Service is responsible for referring appropriate consumers to SHSOP via the CCC and communicating appropriate information on referral in a timely manner.</p> <p>SHSOP is responsible for providing a liaison service and communicating to the Stroke Service.</p> <p>All services are responsible for liasing with each other regarding outcomes of assessment, care plans, ongoing care and providing advice as required to ensure the consumer receives care that meets their needs in a timely and appropriate manner.</p> <p>The Stroke service and SHSOP are responsible for agreeing transfer of consumers to/from care of SHSOP</p> <p>All services are responsible for agreeing care pathways for appropriate consumers groups as required. This may include shared care planning and ongoing management as appropriate.</p>

## **Exclusions**

**This service specification does not include:**

- **Neurosurgical services for management of people with subarachnoid haemorrhage**
- **Paediatrics**
- **Services purchased by ACC**
- **Services purchased by DSD**

## **5. Quality Requirements**

**Stroke services must comply with the Standard Terms and Conditions and Provider Quality Specifications as set out in Crown funding Agreements or Service Level Agreements as applicable. Stroke services must also comply with requirements set out in the over-arching Tier 1 Specialist Medical and Surgical Service Specifications.**

**The service will be required to comply with the General Terms and Conditions and the Provider Quality Specifications as defined in the C&C DHB contract. The service will be required to meet**

- 1. NZS 8134:2001 Health and Disability Sector Standards**
- 2. NZS 8142:2000 Infection Control**
- 3. NZS 8141:2001 Restraint Minimisation and Safe Practice**

**The service will develop a plan to improve access to the service by Maori, Pacific, consumers from other ethnic groups and those in low socio-economic groups who access services disproportionately relative to health need.**

### **General**

**The provider is responsible for implementing a strategy for planning, implementing and reviewing service delivery to clients, from a client perspective. All clients should be involved in the development of their service plan and personal outcome objectives. In addition, outcome measures should be developed for each client, their family and whanau.**

## **Access**

**Services based in a facility should be provided from facilities that are easily accessible to the client and should meet New Zealand Standards 4121.**

## **Acceptability**

**The service should be provided in a way that is sensitive to the needs of the community within which the provider operates and should have effective working relationships based on co-operation with a range of relevant community and support link groups.**

**Client satisfaction surveys should explicitly measure satisfaction with the service.**

**In addition, acceptability to Maori should be included in the review conducted by the provider in conjunction with Maori. Support services for Maori should be proactively offered and available.**

## **Safety and Efficiency**

**The provider will ensure that all persons who supply or provide or assist in the provision of this service are competent, appropriately qualified and, where relevant, currently registered with or licensed by the appropriate statutory and/or professional body.**

## **6. Information Requirements**

**At a minimum the service will collect the following information for all patients seen by the service:**

- **Patient NHI**
- **Patient ACC number if applicable**
- **Patient Name**
- **Patient Date of Birth**
- **Patient Gender**
- **Patient Ethnicity**
- **Contact Details**
- **Next of kin/carer details including contact details**
- **Referral source**
- **Referring Practitioner Name or name of referrer**
- **Referring Practitioner Registration Number (where possible)**
- **Date of referral to service**
- **Reason for Referral**
- **Date of first assessment with service**
- **Outcome of referral eg accepted/declined (with reason)**
- **Date of service starting**
- **Residence on admission**
- **Level of function on admission**
- **Type of stroke**
- **Relevant diagnoses**
- **Level of function at discharge**
- **Residence on discharge**
- **Date of discharge**
- **Number and type of contacts**

## **7. Key Performance indicators (examples)**

- **Proportion of stroke inpatients spending at least 50% of their in-patient stay in dedicated stroke area**
- **The presence of a lead stroke physician for stroke service**
- **Proportion of Neurovascular OP referrals seen within 7 days**
- **Proportion of consumers screened for swallowing disorders within the first 24 hours of stroke**
- **Proportion of patients undergoing a brain scan within 48 hours of stroke.**
- **Proportion of patients commenced aspirin by 48 hours after stroke**
- **100% of patients undergoing Physiotherapy assessment within first 72 hours.**
- **100% of patients undergoing an assessment by an occupational therapist within seven days (excluding those in not expected to survive)**
- **Proportion of patients weighed at least once during admission.**
- **Proportion of patients whose mood was assessed during admission.**
- **Proportion of patients on antithrombotic therapy by the time of discharge**
- **100% of patients undergoing rehabilitation have rehabilitation goals agreed with the multidisciplinary team**
- **100% of patients with whom a home visit is performed before discharge when this is identified in discharge planning**