



strokefoundation

**Consultation on the Draft Clinical Care Standards
Australian Commission on Safety and Quality in Health Care
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13 May 2014

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To Whom It May Concern:

The National Stroke Foundation welcomes an opportunity to provide feedback on the draft Clinical Care Standard for stroke. We see the development of this Standard as a vital step in helping to determine the quality of stroke care being provided in Australian hospitals and ultimately to support efforts to improve care. When this Standard is finalised and publicly released we would urge the Commission to call for resources to be allocated that support the clinical community to monitor and improve standards of care that will deliver better outcomes for stroke patients.

This submission provides feedback on the 'questions of particular interest' outlined in the Consultation Draft document.

Questions of particular interest

- How well does each quality statement cover the key aspects of care that it describes? Please provide any comments you may have, and evidence to support any modification to a quality statement.

Quality statement 1 – Stroke assessment

Referring to the section on what the quality statement means for Consumers, the Stroke Foundation would suggest adding some extra wording to explain to consumers why this is important. i.e. Because faster assessment increases your chances of surviving a stroke and avoiding stroke related disability.

Referring to the section on what the quality statement means for Clinicians we would suggest that the wording may be incorrect. FAST will not **determine** if it is a stroke – a clinical assessment in a hospital setting is required for this. The 'validated screening tool' is used to determine if a stroke is likely and to assist in decision making about transport and triage. We would suggest rewording of this statement to reflect this.

Quality statement 2 – Thrombolysis

The Stroke Foundation supports this quality statement as it is currently worded.

Quality statement 3 – Acute stroke care

Referring to the section on what the quality statement means for Consumers we would suggest that this wording be changed to read:

"If you have a stroke, you can expect treatment in a stroke unit within an established network of people, services and hospitals to make sure that your treatment will be provided in the right place, at the right time"

It is our view that specific reference to stroke unit care is required as international evidence indicates that this has the greatest impact on health outcomes resulting from stroke and therefore it needs to be part of any quality statement.

Referring to the section on what the quality statement means for Health services we would suggest additional wording be included to ensure clarity regarding the definition of a 'formal network of stroke services'. Alternative paragraph could read:

"Ensure that the systems, infrastructure and resources are in place for patients with stroke to be treated in a stroke unit supported by a formal network of stroke services (a service that promotes rapid transport and triage and has systems to promote transition from the acute phase to home, residential care, sub acute care or palliative care.)"

In relation to this quality statement we would also like to inform the Commission that there is a review underway of the Acute Stroke Services Framework 2011 and the outcomes of this review have the potential to impact this statement.

Quality statement 4 – Initiation of rehabilitation

Referring to the quality statement we would suggest a variation in the wording to reflect that rehabilitation should start as early as possible in the acute hospital stay. Current wording would allow for rehabilitation to start any time during the acute admission including just prior to discharge, whereas the indicator looks to measure the proportion of patients who commence rehabilitation within 48 hours of initial assessment.

The wording of the statement could read:

"A patient's rehabilitation needs and goals are assessed within 24 hours of admission to hospital and this directs rehabilitation therapy that starts as early as possible during the acute hospital admission."

Referring to the section on what the quality statement means for Consumers we would suggest that current wording is not consistent with the quality statement and that it should be edited to read:

"If you have had a stroke, your rehabilitation needs and goals will be assessed within 24 hours and your therapy will start while you are in hospital."

With regard to this quality statement we would also like to draw the Commission's attention to the Australian Stroke Coalition's Assessment for Rehabilitation: Pathway and Decision Making Tool. We believe this to be an example of a high quality rehabilitation assessment tool that could be recommended for broad use within hospital services. A copy is attached to this submission.

Quality statement 5 – Stroke prevention

Referring to the section on what the quality statement means for Consumers we would suggest adding examples of lifestyle change advice to provide clarification for consumers and add the word 'and' to ensure it is clear that consumers could be provided with medicines **and**/or advice. The statement could be edited to read:

"To reduce your future risk of a stroke, you will be assessed and provided with medicines and/or advice on lifestyle changes (e.g. Diet, smoking, physical activity, blood pressure monitoring etc) that may reduce that risk.

Quality statement 6 – Carer training and support

Referring to the quality statement we would suggest this should be reworded so it is clear it applies only to carers of people requiring assistance. This distinction is picked up in the indicator but not in the statement. We would also suggest that this quality statement should incorporate reference to appropriate supports being provided to carers when they need it. The title refers to ‘carer training and support’ but the statement currently only refers to training.

Referring to the section on what the quality statement means for Consumers we would suggest adding some extra words to clarify that it is clear that this is for carers of people requiring assistance. If it is agreed to include a reference in the statement to appropriate support being provided to carers when they need it then this will also need to be reflected in this section.

Quality statement 7 – Individualised care plan

Referring to the quality statement we would suggest extra wording be added to ensure it is clear that in providing the individualised care plan to the patient’s general practitioner this is in addition to the provision of the standard hospital discharge summary. The final sentence of the statement could read as follows:

“This plan is also provided to the patient’s general practitioner and is in addition to the standard hospital discharge summary.”

Referring to the section on what the quality statement means for Consumers we would raise a question of whether the words ‘tailored care plan’ might be inaccessible language for consumers. A different description may help. We would also suggest that consumers could be directed to the ‘My stroke care plan’ resource that was developed by the Australian Stroke Coalition as an example. A copy of this document is attached to this submission.

In this section we would also suggest adding medications to the list of things included in the care plan given the Clinical Guidelines for Stroke Management 2010 (section 5.2, page 70) recommend information and education in hospital (and in the community) to support adherence to pharmacotherapy.

Referring to the section on what the quality statement means for Clinicians we would suggest inclusion of an extra element in the second sentence, which describes what should be included in the care plan. We would suggest the second sentence could read as follows:

“This care plan will include information about the patient’s risk factors and risk reduction strategies including rationale for medications, equipment required, and the contact details of ongoing support and services available in their community.”

In this section we would also suggest, as per the wording in the statement, that it be made clear that providing the care plan to a patient’s general practitioner is in addition to the provision of the standard hospital discharge summary.

Likewise there may need to be clarification of the wording in the section on what the quality statement means to Health services.

General comments about the statements

While the Stroke Foundation agrees with the quality statements that have been included in the Clinical Care Standard we believe there is a gap relating to provision of education and information for stroke survivors and carers.

All of our consultation with consumers has identified provision of education and information about stroke as being critical in supporting stroke recovery and self-management and we believe it must be included in the Standard.

While it might be possible to modify quality statement 7 to capture this element it is our view that a standalone statement is required. Quality statement 7 refers to the period of care where patients are being transitioned out of the acute setting whereas information and education must start being provided on day 1 with information about 'what has happened to me', 'why?', 'what can I expect', etc.

- What factors currently prevent the care described in the Clinical Care Standard from being achieved?

A significant factor relates to the fact that the Clinical Guidelines for Stroke Management 2010 will soon be out of date and in their current state they won't support the quality statements. The guidelines are designed to support clinicians to deliver best-practice stroke care however they are in need of an update to reflect emerging evidence in a number of areas. The Stroke Foundation recently wrote to the Minister for Health to alert him to this fact and the potential for this to impact hospital care quality. The letter included a request for the minister to provide funding to support guideline review and updating.

While there is reference in the draft Standard to a 'formal stroke network' there is currently no formal definition of what this is. A definition will be included in the Acute Stroke Services Framework following the current review and the revised Framework will be released later in 2014.

Another factor that will impact on standards being achieved is the shortage of stroke units. There are 5 large hospitals seeing around 600-700 patients that do not yet have a stroke unit. We understand that several of these are in the planning stage however not all are.

In addition, existing stroke units are often too small to cater for the number of stroke patients admitted to the hospital. This is exacerbated by the fact that around a quarter of stroke unit beds are used to treat patients with other diagnoses leading to stroke patients being treated outside the stroke unit. Addressing the issues related to bed numbers, and stroke unit bed availability, is critical to ensure swift admission of patients to a stroke unit.

Systems for rapid transport of patients to hospitals with tPA are not yet in place in all the hospitals where they are needed. This factor is offset somewhat by the increasing number of hospitals now providing tPA.

Finally, quality statements and their monitoring are not mandated and, as the NSF understands, there is no current plan to introduce such a process. This will be a significant factor in relation to adherence to the standard.

- What factors will support the practical application of this Clinical Care Standard?

We would suggest several key actions would help to support practical application of the Standard.

Firstly it is vital that the Clinical Guidelines for Stroke Management are up to date and reflect best evidence that is consistent with the Standard. As pointed out this is not currently the case and there is an urgent need to update the Guidelines.

We would suggest development of a communication strategy including all health departments to support dissemination, awareness raising as well as education and training around the Standard. The strategy should have consideration for existing networks and channels such as the Australian Stroke Coalition which can provide a potential support mechanism to help see the Standard implemented and may form conduit for education and information sharing.

There needs to be an effective system to monitor the Standard through data collection and quality improvement. This system needs to be nationally mandated, funded and standardised. The Australian Stroke Coalition is currently developing an Australian Stroke Data Tool and a National Data Dictionary to assist with standardisation and to reduce the burden that data collection can place on clinicians.

Clinicians and health systems need support and education to modify clinical care and processes when standards are not being met. This would include comprehensive quality improvement support to identify local barriers and tailor local solutions and actions based on audit and feedback to identify where gaps in care exist – this comprehensive package is currently not in place across the country.

There is existing material that could support practical application of the Standard. This includes the Australian Stroke Coalition produced Care Plan, Australian Rehabilitation Tool, as well as the Stroke Foundation Acute Stroke Services Framework that is currently under review.

The Stroke Foundation's Health Professional Portal and Consumer Portal (both under construction) may provide a mechanism to support implementation. The Stroke Foundation would welcome the opportunity to discuss this further at the appropriate time.

It's also worth noting that current hospital admission patterns will assist with achieving the Standard. 90% of strokes are currently admitted to hospitals that have, or should have a stroke unit (over 100 stroke admissions per year). This provides a clear focus for quality improvement efforts.

Finally the effective use of telemedicine has the potential to support adherence to the Standard.

- How relevant are the suggested indicators in supporting the monitoring of the quality statements at the local health service level? Please provide any comments you may have, and evidence to support any modifications.

Quality statement 1 – Stroke assessment

Referring to CCS.Stroke.1a we would point out that pre-hospital measures are being considered as part of the national data dictionary development. Ideally 1a would have wording more consistent with 1b however, this would require ambulance and hospital data to be linked to be able to determine 'final diagnosis of stroke'.

Quality statement 2 – Thrombolysis

Referring to CCS.Stroke.2a we would ask whether this should specify transported 'by ambulance'.

Further we would suggest that 3.5 hours be considered to be changed to 4.5 hours given this is the cut off time for administering thrombolysis. We would question the value in sending a message to ambulance that after 3.5 hours there is no point going to a tPA hospital, especially given documented evidence shows hospitals continue to improve their 'door to needle' time and many are currently administering tPA in far less than an hour after arrival.

Quality statement 3 – Acute stroke care

The Stroke Foundation supports these indicators in their current form.

Quality statement 4 – Initiation of rehabilitation

Referring to CCS.Stroke.4c we would question the sensitivity of this indicator given how difficult it would be to measure and question its usefulness to drive improved care. We would suggest a more focused indicator be determined.

Quality statement 5 – Stroke prevention

Referring to CCS.Stroke.5b we would suggest removing the 'or' in this indicator as recommendation is for patients with ischaemic stroke to be on all three therapies unless contraindicated.

Quality statement 6 – Carer training and support

The Stroke Foundation supports these indicators in their current form.

Quality statement 7 – Individualised care plan

The Stroke Foundation supports these indicators in their current form.

- How should the Clinical Care Standard be disseminated (e.g. web based resources, printed resources, etc)?

As per our suggestion above we would welcome a broad communication strategy including all health departments to support dissemination, awareness raising as well as education and training around the Standard. The strategy should have consideration for existing networks and channels (Australian Stroke Coalition; Stroke Foundation Health Professional Portal; Consumer Portal etc) which can provide a potential support mechanism to help see the Standard implemented and may form conduit for education and information sharing.

- Do you have any general comments in relation to each Clinical Care Standard?

We would like to use this section to make general comments about the Standard.

Firstly, the Stroke Foundation would like to refer to commentary in the 'Context, Emerging models' section around the 'hyper-acute stroke units' experience in London. While acknowledging that this policy has had some success in a large metropolitan area in the UK we would advise caution in making any assumptions about how this might be replicated in Australia given very different geographic health system considerations.

We would also like to provide some feedback on '24 hour' reference in the glossary definitions for 'Stroke' and 'Transient ischaemic attack'. While this is referenced in the Clinical Guidelines for Stroke there is a growing view among clinicians that the 24 hour definition is now out-dated and can create issues in emergency departments. We would suggest that this might be worthy of further discussion. It is further evidence of the need to update the Clinical Guidelines to reflect current best-practice.

Thank you for the opportunity to provide feedback to this important process and we look forward to seeing the Standard finalised and released. Please direct any questions or queries regarding this response to the National Stroke Foundation Director, Advocacy, Rebecca Smith on rsmith@strokefoundation.com.au or 0466 217 988

Yours sincerely,



Rebecca Naylor
Acting Chief Executive