Facilitating earlier transfer of care from acute stroke services into the community

This article outlines the implementation of a model to shorten the length of stay in acute hospitals for patients admitted with stroke.

AUTHOR Jennifer Robinson, BSc, RGN, is lead nurse for older people, Walsall Manor Hospital.


This article outlines an initiative to reduce length of stay for stroke patients within an acute hospital and to facilitate earlier transfer of care. Existing care provision was remodelled and expanded to deliver stroke care to patients within a community-bed-based intermediate care facility or intermediate care at home. This new model of care has improved the delivery of rehabilitation through alternative and innovative ways of addressing service delivery that meet the needs of the patients.

INTRODUCTION

Stroke has a major impact on individuals’ lives and that of their families, as well as on the nation’s health and economy. It is the third most common cause of death and the largest cause of disability in the UK (Department of Health, 2007).

Standard 5 in the National Service Framework for Older People (2001) set goals of reducing the incidence of stroke and ensuring that those who have had a stroke have prompt access to integrated stroke care services.

Walsall integrated stroke services in compliance with the recommendations in the NSF and was already an established service with key components in place:

- A preventative strategy;
- Transient cerebral ischemic attack service (TCIA);
- 18-bed acute stroke unit;
- 28-bed stroke rehabilitation unit;
- A lifelong follow-up programme;
- Four stroke maintenance centres.

There was an established care pathway in operation, which mapped the patient journey from acute through to rehabilitation and ongoing care in the community. However, the average length of stay for patients at the acute hospital was 46 days, which was above the national average.

POLICY BACKGROUND

In 2005 the National Audit Office stated the average length of stay in the acute hospital was 28 days. It meant that, in our unit, the length of stay was 18 days more than the average and therefore needed to be reduced.

The DH document Mending Hearts and Brains (2006a) stressed the importance of early support discharge schemes. This was further supported by the white paper Our Health, Our Care, Our Say (DH, 2006b), which stated that patients wanted and preferred care that was closer to home. It provided strong evidence that early discharge from acute care needed to be facilitated and was what the client wanted.

IMPROVING THE SERVICE

Project aims and outcomes

Walsall Manor was carrying out a bed reduction plan so it seemed an opportune time to review the stroke clinical care pathway and promote a 28-day framework and pathway of care. The aims of the project were to:

- Ensure the efficient and effective use of stroke beds within the trust;
- Ensure the service followed best-practice guidance and was evidence based;
- Ensure earlier facilitation of transfer of care from the acute to the community setting, thereby reducing length of patient stay;
- Develop a competent and skilled multidisciplinary workforce to meet the needs of the clients.

Implementation

The NHS Institute for Innovation and Improvement (2005) gold standard pathway acted as a catalyst for service improvement.

The 28-day model was implemented in July 2007 in preparation for the planned bed reduction, which would result in one 28-bed stroke unit by September 2007 (there had been a 28-bed stroke rehabilitation unit and an 18-bed acute stroke unit – 46 beds in total). It was achieved through collaboration between Walsall Teaching PCT, social services and local authority home care staff.

Transferring clients earlier into the community setting involved significantly more than just changing the existing culture. Work needed to be undertaken before the new service was set up to enable and support change across the whole health economy.

An initial project group was set up to implement the plan and, while this was led by the acute trust, there was multidisciplinary representation (managers and clinical staff) from all partner agencies. The change in working practices for the therapy staff
necessitated consultation.

The new model was mapped out so that at specific timescales in the patient journey a decision is made regarding their medical stability and their fitness for transfer of care.

Discharge options were identified and included:
- Discharge home with intermediate care at home and therapy provision if rehabilitation was needed;
- Discharge home with intermediate care at home, therapy provision if rehabilitation was needed plus a home care package;
- Discharge home with therapy provision if needed;
- Discharge into a community bed-based intermediate care facility.

Whichever care option was followed, the decision was based purely on the patient’s physical needs.

The distinctive feature of this model is the fact that the acute therapy staff continue the therapeutic management of the patient when they are discharged from hospital, regardless of their destination. However, this only applies to patients who are discharged before day 28 of their stroke incident. At day 29, care is transferred to the community stroke teams. Where clients are transferred before day 28, the community teams would be notified of a potential transfer of care.

**Training**

Integral to the success of this project was ensuring that there was a competent workforce able to meet the challenges of the new model. The team needed to ensure that staff possessed the necessary skills and competence to meet patients’ needs, as well as education and knowledge around the concept of rehabilitation.

It was very important that the team devised a comprehensive educational training plan, which would consider not only the physical impact of the stroke but also the emotional and psychological effects. Induction workshops for all new staff entering the service were already in place and occurred three times a year. An additional workshop was set up to account for all the extra staff that would now become involved in the care and management of stroke patients. Ongoing education and training will continue once the project has been implemented.

Therapy staff developed a competency-based training programme, which focused on the principles of effective stroke management and comprehensive care planning. With the expansion of intermediate and domiciliary care, the team needed to ensure that staff received appropriate training to be able to negotiate and understand agreed therapeutic management plans. This was to ensure that the patients were receiving effective stroke rehabilitation. This training was provided at a set venue over a period of weeks to allow maximum attendance of all staff within bed-based facilities and domiciliary care staff.

Within the acute ward setting, staff received information on the proposed model and were fully engaged in the process. They needed to be able to understand the processes and the rationale for this new model so that they would be in a position to inform and discuss with patients and relatives during their initial goal-setting meetings.

**Monitoring and evaluation**

Monitoring and evaluation was built into the project and it was agreed that this would comprise predominately quantitative data.

As one of the main drivers for change was length of stay, the team needed to ensure that these figures were collected internally by the acute trust and reviewed to evaluate the effectiveness of the project. There was also agreement that ongoing monitoring and evaluation of the service would take place through the monthly operational group and strategic group meetings. In addition, therapy outreach figures were collected at monthly intervals.

**Outcomes**

The length of stay has been reduced in line with the new target of 28 days. Clients are transferred earlier into community services and, more importantly, hospital beds are being used more effectively and efficiently.

By September 2007, a 28-bed stroke unit had been set up, although there was variation in terms of capacity: bed numbers sometimes increased from 28 to 33.

In terms of qualitative data, while patients prefer earlier transfer, the psychological impact of the stroke for the patient and their family remains high, as does psychological adjustment. They continue to receive support from multidisciplinary team members, predominately the clinical psychologist and family support worker.

No formal evaluation of client satisfaction has taken place but there are plans to carry out a client satisfaction survey this year.

**CONCLUSION**

Length of stay is a key driver and care closer to home is fundamental to any model of care delivery. The National Stroke Strategy (DH, 2007) is a framework of quality markers for raising the quality of stroke prevention, treatment, care and support. It enables providers and commissioners to plan improvements and to benchmark provision with the recommendations in the strategy.

Walsall Integrated Stroke Service will continue to evaluate its facilities to ensure that it continues to meet the needs of the clients and also to ensure that care delivered is evidenced based and adheres to best-practice guidance.

**REFERENCES**


NHS Institute for Innovation and Improvement (2005) Delivering Quality and Value Focus on: Acute Stroke. tinyurl.com/qual-stroke