South London
Cardiac and Stroke Network

Inpatient and community stroke rehabilitation services: A guideline for best practice

Sharing best practice across South East London

The stroke rehabilitation group for the South East London Cardiac and Stroke Network combines representation from inpatient and community services serving stroke patients throughout the boroughs. Together, they developed these best practice guidelines for commissioners of healthcare across the sector.

INPATIENT AND COMMUNITY STROKE REHABILITATION SERVICES: A GUIDELINE FOR BEST PRACTICE

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Background

In December 2007, the Department of Health published the National Stroke Strategy, which provides a quality framework against which local services can secure improvements to stroke care and address health inequalities. The same year, Healthcare for London: A Framework for Action set out ambitious plans to improve the quality of health services across London.

In November 2008, Healthcare for London (HfL) commissioned and published the *Stroke Strategy for London* in response to the Royal College of Physicians 2008 National Sentinel Stroke Audit. The audit had identified that improvements in stroke care in the capital had been slower than the rest of the country and, in some cases, performance had worsened.

One of the key issues highlighted in the Stroke Strategy for London was the wide variation of availability of rehabilitation and community care services, with some areas having no dedicated community stroke service at all. In response to this finding, HfL published a stroke rehabilitation guide in November 2009 which provides five key recommendations for commissioning quality stroke rehabilitation services.

Against this background, the stroke rehabilitation workstream of the South East London Cardiac and Stroke Network (SELCSN) has developed these simple, brief guidelines for good quality rehabilitation services by sharing expert opinion and knowledge of best practice across the sector. The group, which consists of both clinicians and commissioners, has representation from every borough in South East London and covers both inpatient and community rehabilitation services. These recommendations are intended to be used in conjunction with the HfL Stroke Rehabilitation Guide and are grouped under:

- Development of services
- Collaborative working
- Communication, information and support
- Others

'These recommendations are intended to be used in conjunction with the HfL Stroke Rehabilitation Guide…'

Recommendations

A. Development of services

1. Stroke patients should be able to access comprehensive, community-led, high quality specialist stroke care and rehabilitation immediately after discharge from hospital (within 24 hours). This is essential in order to implement care plans agreed by the multi-disciplinary team (MDT), patients and their carers

2. Early supported discharge (ESD) should be an integral part of comprehensive community specialist stroke services, and should be made available to all patients whose care and rehabilitation needs can be appropriately met by ESD. The ESD service should have the capacity to provide care and rehabilitation seven days a week and up to four times per day where this is indicated by the patient's care plan.

'Early supported discharge should be an integral part of comprehensive community specialist stroke services…'

3. The community stroke service should consist of a multi-disciplinary team with highly developed stroke-specific skills. The service should work to individualised care plans that are developed in conjunction with the patient (and their carer) and reviewed and modified on a regular basis during the rehabilitation period.

4. A stroke competencies framework to support service delivery should be used across the pathway.

5. Rehabilitation support workers should be an integral part of the community stroke service. They should be trained specifically in stroke competencies and work under direct supervision of health and social care professionals.

6. Every community stroke service should provide management of stroke patients as a long-term condition. This should allow patients to re-access rehabilitation services at any point along the pathway. Such a service could include, but is not limited to, MDT reviews, orthotic and mobility aid management, wheelchair services and counseling.

7. Where the provision of community services is complex and varied, there should be a single point of access for referrals to all stroke services.

8. There should also be a single point of access for stroke service users and other health and social care professionals.

9. All appropriate stroke patients should have access to vocational rehabilitation services.

B. Collaborative working

There should be systems and processes in place to ensure that collaborative working between primary, secondary, social care and voluntary services are formalised and embedded within stroke services. This might consist of:

1. Staff from community stroke services to attend MDT meetings on the hospital stroke units to assist with discharge planning and to discuss long-term goals for the patients' rehabilitation once they are in a community setting.

2. Planning of discharge from the inpatient units should begin early in the patients' stay on the unit.

3. "In-reach" or "out reach" between hospital and community teams should be an option prior to patient discharge for issues such as joint assessments, patient and carer education, and to promote a smooth transfer of service.

4. There should be a robust and effective handover of referrals and information between inpatient and community stroke teams.

5. There should be a named social worker, experienced in stroke care, involved with all community stroke teams.

6. There should be regular stroke multi-disciplinary meetings in the community with stroke consultant input or access to a stroke consultant physician.

7. There should be an integrated approach between health and social care providers and to ensure that paid carers are adequately trained and supervised.

8. Hospital teams should clearly communicate to community teams the outcome measures used and the scores achieved when patients transfer from one service to the next.

"Planning of discharge from inpatient units should begin early in the patient's stay on the unit…'

C. Communication, Information and Support:

1. Patients and carers should be involved in setting goals and care planning in both the hospital and community settings.

2. There should be stroke family/carer support workers available for all patients and their families, such as those provided by The Stroke Association.

3. All stroke patients should have access to conversation, communication and support groups where appropriate.

4. There should be MDT records in the hospital stroke units as well as in the community.

> *"Patients and carers should be involved in setting goals and care planning…'*

5. Patient-held records should be multi-professional and easily accessible to all professionals providing care to the patient. This will aid communication between patients, families and staff. For example, this record may take the form of a diary.

6. Consistent and clear methods of providing useful information to patients and carers should be established for every stroke service. For example, a patient handbook, such as the one developed by the Moderisation Initiative, may be started in hospital and continued in the community.

7. Promoting self-efficacy and self-management should be incorporated into the long-term goals for all patients. A good example is the Stepping Out Programme.

D. Other

1. All stroke patients, including those discharged to nursing or residential homes, should have access to assessment and treatment and reviews as appropriate. This may be part of a long-term neurodisability management and support programme for family and carers.

2. A clinical neuro-psychology service should be part of every inpatient as well as community rehabilitation service.

3. Service users should be meaningfully involved in all aspects of redesign and improvement.

4. Services should produce outcomes for monitoring using qualitative and quantitative tools.

Contributors

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