

Stroke: improving transfer of care pathways

While the management of stroke care has improved, there are still lapses in communication between primary and secondary settings – leaving many patients with a feeling of ‘abandonment’ when they leave hospital. The National Sentinel Audit of Stroke conducted a survey of services and in response to their findings developed the Stroke Transfer of Care document for clinicians. **Dr Anthony Rudd** reviews its development, practical value and use.

Underpinning the concept of care pathways is the aim to treat the right patient at the right time in the right way. According to the National Co-ordinating Centre for NHS Service Delivery and Organisation (NCCSDO), a core element in achieving this continuity of care is ‘effective communication between professionals and services and with patients’¹. The process of transfer of care between primary and secondary settings, and associated discharge planning, plays a major role in ensuring effective communication and, therefore, facilitating continuity of care. Discharge planning has been associated with improvements in readmission rates and health outcomes in many settings, including hospitalised elderly², congestive heart failure³ and hip fractures⁴. Similar advances in stroke care have not, as yet, been reported. In fact, surveys routinely highlight that one of the problems most often experienced by stroke patients is a major chasm in the care pathway between secondary and primary care, and a feeling of abandonment when they leave hospital.

Stroke care in the community

According to the Royal College of Physicians (RCP), 120,000 people in the UK have a first stroke every year and of these 90,000 are discharged from hospital⁵. Many will have persisting impairments that require continuing treatment and support; all

will need to be carefully monitored to minimise the risk of recurrent stroke. It is therefore vital there is effective communication between the hospital clinicians and those in the community.

The management of stroke patients has improved dramatically over the last 10 years. The rate of death and disability has been reduced as a result of a heightened awareness in the importance of care in specialist stroke units. Added impetus for improved care came in 2001 with the publication of the National Service Framework (NSF) for Older People, containing a demand that all hospitals treating stroke patients establish a specialist service by April 2004⁶. However, the progress made in hospital care has not been paralleled by improvement in community facilities. Evidence of a ‘best practice’ deficit in primary care was highlighted by the National Sentinel Audit of Stroke published in 2005, which showed that only 79 per cent of known hypertension patients were on blood pressure lowering medication and 25 per cent of people with a previous history of stroke or transient ischaemic attack (TIA) were not on anti-thrombotic medication⁷.

The National Sentinel Audit of Stroke also examined the quality of care given to patients admitted to all hospitals in England, Wales and Northern Ireland⁷. Each hospital conducted a

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Key points

- > One problem often experienced by stroke patients is a major chasm in the care pathway between secondary and primary settings, and a feeling of abandonment after leaving hospital.
- > Information sent to primary care when patients are discharged tends to vary greatly in detail and consistency.
- > A Stroke Transfer of Care (ToC) document has been developed as a concise resource for all clinicians.

retrospective case note review of the services provided in up to 40 patients. Only 25 per cent of hospitals had access to specialist stroke teams in the community and only 45 per cent had established protocols for stroke management agreed between primary and secondary care. Deficits in information exchange between settings was shown by the fact that GPs were informed on the day of death or discharge that one of their patients had a stroke in just 65 per cent of cases. Furthermore, discharge summaries containing information about functional ability were provided in only 57 per cent of cases.

Transfer of care document

The information sent to primary care when patients are discharged tends to vary greatly in detail and consistency. This prompted the development of the Stroke Transfer of Care (ToC) document. The main aim of this tool is to help clinicians improve the quality of the care they provide. It is designed to be a concise resource that contains all of the information the primary care team will need to provide seamless care. Additionally, the ToC can facilitate the collection of data required for the General Medical Services (GMS) contract.

The Stroke ToC document allows the efficient transfer of information on diagnosis, detailing the key investigations undertaken in secondary care and all recommendations for secondary prevention, including:

- > current and target blood pressure;
- > indications for pharmacological therapy;
- > appropriate lifestyle advice;
- > current physical disability;
- > cognitive ability;

- > plans for further rehabilitation and social support.

The document fulfils the criteria set out by the NCCSDO to allow effective transfer of information across settings and is available in both paper and electronic format. Copies are stored at both primary and secondary care centres, and a copy can be given to the patient accompanied by an explanatory leaflet. This leaflet gives further information to support those who have suffered a stroke in their transition from the hospital to home environment.

Successful pilot

As part of the development process, a pilot study was conducted across nine secondary care sites in areas of the UK such as Belfast, Liverpool, Dundee and London. The document was sent to 180 GPs and its usefulness to both secondary and primary care practitioners was evaluated. The results were positive. From the viewpoint of secondary care, a significant proportion of the consultants involved in the pilot (78 per cent) said they would recommend it to their colleagues. Furthermore, on a rating scale of one (poor) to five (excellent), the vast majority (89 per cent) of the consultants rated the usefulness of the document as a four or five. A statement from one of the consultants involved in the pilot summed up the general attitude of secondary care practitioners: 'This document is excellent. It tells GPs exactly what they need to know to confidently continue the management of their stroke patients once they leave hospital. I will definitely recommend the Stroke ToC document to my colleagues.'

Similarly successful results were generated in primary care. Nearly all of the GPs involved in the pilot (88 per cent) said the document helped them manage their patients more effectively. Like their secondary care counterparts, the vast majority of GPs (89 per cent) gave the document a usefulness rating of four or five. Almost all GPs (92 per cent) stated that they did not receive a document similar to the ToC when their stroke patients left hospital and 83 per cent felt it would be of help in managing them more effectively. GPs reported that all sections of the document were useful, and the section on key investigations particularly informative. One GP commented: 'This tool goes a long way in ensuring that the transferral of care from the secondary to the primary care teams is comprehensive and uninterrupted.' In a further positive feature of the pilot study, the successful results of the standard evaluation were supplemented by unprompted feedback from key colleagues who commended the

Stroke ToC document and called for it to be adopted in clinical practice.

Conclusion

As outlined in the introduction, successful ToC strategies have been employed in other therapy areas, so the concept of a stroke ToC document is not revolutionary. Effective stroke care is about delivering simple things well and, as in other therapy areas, the Stroke ToC can facilitate this delivery. It fulfils the need of effective cross-setting information exchange and the results of the pilot study suggest it will be of significant value in the routine management of patients with stroke. Therefore, we would recommend all patients are discharged from hospital with this or a similar document. More detailed research will be needed to discern all of the benefits – and any limitations – of this Stroke ToC document. However, at this point in time, the use of the Stroke ToC document will avoid the need for every trust to devise its own system. Furthermore, the widespread use of a common format, regardless of where the patient is treated, will enable better communication across geographical and organisational boundaries. The development of systems to improve continuity of care must not fall into the trap of becoming paper or ‘box ticking’ exercises. As with all initiatives in healthcare, the ultimate aim is to improve outcomes, including the quality of life of the patient. A lack of effective shared care may have limited the ability of clinical advances to fully impact the burden of stroke. This document will contribute to bridging the gap between the potential of modern stroke management and the long-term well-being of the patient.

Conflict of interest: none declared.

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