Transfer of Care Guideline for Stroke Patients
Stroke Reperfusion Workgroup

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Scope

NSW Health is working collaboratively with Ambulance Services NSW and NSW ACI Stroke Services to improve the patient journey from onset of acute stroke symptoms to access stroke thrombolysis for patients with ischaemic stroke.

Objectives of the Early Access to Stroke Thrombolysis Program are to:

- Improve **early access to thrombolysis** for ischaemic stroke patients;
- Improve **pre-hospital assessment** by paramedics for identification of stroke through a validated standardised assessment tool;
- Improve in-hospital reception, assessment and management of stroke patients to achieve early access to safe reperfusion.

The Early Access to Stroke Thrombolysis Program will train paramedics in recognition of stroke that is possibly amenable to thrombolytic therapy. Evidence shows that thrombolysis should only be delivered in emergency departments, stroke care units or high acuity unit with adequate expertise and infrastructure for monitoring, rapid assessment and investigation of acute stroke patients.

Early detection by paramedics will allow for these patients to be transported to a hospital that offers a 24/7 stroke thrombolysis service, where appropriate. Following early access to a Computed Tomography Scan (CT scan) and neurology review, patients will be deemed appropriate or not appropriate to receive thrombolysis and receive the appropriate treatment accordingly.

This program will include policy, guidelines and governance for the repatriation of patients back to a local referral service, post acute phase of care and close to the patient’s place of residence, where possible.

The project steering committee is/has:

1. Confirmed governance for 24/7 Acute Stroke Thrombolysis Centres (18 centres)
2. Confirmed governance for 24/7 Non-Thrombolysis Acute Stroke Units (15 centres)
3. Approximately 3500 Paramedics will complete the recognition of stroke training using the FAST tool by end June 2014
4. A process map which covers the stroke patient journey across the care continuum has been developed
5. Develop policy, guideline and governance for the transfer of patient’s back to a non-tertiary referral centres post acute phase of care
6. Commence implementation process, prepare a Readiness Assessment Checklist and a Toolkit
Standard Protocol for Transfer of care

- This protocol is for FAST positive patients who have been admitted to an Acute Stroke Thrombolysis Service
- All medically fit patients should be repatriated to an appropriate referral service or centre within 72hours, post acute phase of care
- There should be an efficient operational policy agreed, including an escalation policy. Ideally patients should be transferred from an Acute Stroke Thrombolysis Service to and Acute Stroke Unit (ASU), local to the patient’s place of residence. If it is not possible to transfer patients to a local ASU, the patient should be transferred to a clinically appropriate service with clear plans for management in place.
- There should be clinician to clinician communication to agree on the transfer and confirm that the patient is ‘medically stable’. A Transfer of Care summary with a clear plan for ongoing management and access to scans, previous tests and pathology provided. Take into consideration further tests that are required but not available at the referral service.
- Patients should be transferred to a referral service during business hours i.e. 0800-1800hours, wherever possible
  - Referral service implies the organised transfer to another facility/ward/unit
    - Acute Stroke Unit
    - Hospital ward
    - Palliative Care Centre
    - Rehabilitation ward/unit/facility etc.
- Transfer of care should take place seven days a week.
  - Transfer of care should occur in accordance with the NSW Health Policy Directives
    - PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospital
    - PD2011_031 Inter-facility Transfer Process for Adults Requiring Specialist Care
    - Local Policy Directive: Inter-Hospital Patient Transport Policy

Documentation to accompany Transfer of Care

- Management Plan / Transfer of Care document or Discharge Summary
- Patient documentation
- Advance Care Directives
- PD2008_018 CPR- Decision Relating to No Cardiopulmonary Resuscitation Orders

- There are 3 categories of patients referred to in this guideline:
  1. Thrombolysed Stroke Patients
  2. Non Thrombolysed Stroke Patients
  3. Stroke mimics
Standard Guideline for Transfer of Care

Is the patient medically stable?

**YES**
Transfer to appropriate Clinical Service

**NO**
Remain in Acute Stroke Thrombolysis Centre

**Medically Stable for Transfer to appropriate Clinical Service**

1. Clear diagnosis of stroke & secondary prevention plan
2. Appropriate investigations should be completed prior to referral if they are not accessible at the receiving hospital. E.g., Carotid Doppler, transthoracic echo, transoesophageal echo.

UNLESS there are extensive delays for testing >72 hours, negotiation should occur to enable patient transport back to Acute Service for further required testing.

3. Not dependent on inotropic or ventilatory support
4. Stable level of consciousness (unless palliative)
5. Reliable route of nutrition and/or hydration (NG Tube, PEG Tube and IV line). Ensure the referral service is able to care for patients with these insitu.
**Clinical Pathway for Transfer of Care for Stroke Patients**

- **Within 24 hours of admission and ongoing during the Acute Stroke Thrombolysis Service stay**

- **Clinical Assessment**
  Patient assessed for suitability to transfer

- **Medical Assessment**
  The patient's medical team to assess and confirm if the patient is medically stable for Transfer of Care

- **Nursing Assessment**
  Lead Nurse for Stroke to assess and ensure all the transfer documents are completed
  Eg. Plan for Management
  Advance Care Directive
  NB: in a hub and spoke MoC this will be the responsibility of the Nurse I/c or discharge planner

- **Allied Health Assessment**
  The therapist for Stroke is to ensure all treatment records are completed in patients medical notes

- **Acute Stroke Thrombolysis Service and Referral Service**
  Agreement on date for Transfer of Care
  Ensure the Referral Service contact person details are clearly documented
  Specific facility/ward/unit and contact person

- **Patient Flow Unit**
  Stroke Care Coordinator
  Nursing Unit Manager
  Confirm patient information for Transfer of Care
  Request a bed at referral service
  Confirm date for transfer
  Document referral service patient flow contact details
  Note local Escalation Process for delayed transfers

- **Patient should be repatriated to the referral service within 24 hours of the referral date or documented date fit for transfer or to the first available bed**
1. **Protocol for Transfer of Care for patient’s who have received Thrombolysis**

- This protocol is for FAST positive patients who have been transported to a Acute Stroke Thrombolysis Service, who have been administered thrombolysis
- Assessment for transfer of care should commence at 24hour post admission to the Acute Stroke Thrombolysis service
- Patient must be medically stable, with suitable referral service located based on the patient’s clinical needs
- Prior to transfer of care ensure all required testing is completed, if NOT available at the referral service

- Medically Stable for Transfer to appropriate Clinical Service
  1. Clear diagnosis of stroke & secondary prevention plan
  2. Appropriate investigations should be completed prior to referral if they are not accessible at the receiving hospital Eg. Carotid Doppler, transthoracic echo, transoesophageal echo UNLESS there are extensive delays for testing >72hour, negotiation should occur to enable patient transport back to Acute Service for further required testing
  3. Not dependent on inotropic or ventilatory support
  4. Stable level of consciousness (unless palliative)
  5. Reliable route of nutrition and/or hydration(NG Tube, PEG Tube and IV line). Ensure the referral service is able to care for patients with these insitu
2. Protocol for Transfer of Care if patient NOT suitable for Stroke Thrombolysis

- This protocol is for FAST positive patients who have been transported to a Acute Stroke Thrombolysis Service, but are NOT suitable for thrombolysis.

- Patient’s, who are not suitable for Stroke Thrombolysis, but would benefit from structured stroke care should be transferred to an Acute Stroke Unit local to patient’s residence.

- Patient’s, who are not suitable for Stroke Thrombolysis or Acute Stroke Unit care should be transferred to a clinically appropriate referral service, eg: palliation.

- For the transfer of patients to another facility please ensure that appropriate documentation with Clinical Plan of Management and Advanced Care Directive to ensure patient and family wishes are maintained (specific to palliative care transfer).

### Medically Stable for Transfer to appropriate Clinical Service


2. Appropriate investigations should be completed prior to referral if they are not accessible at the receiving hospital. Eg. Carotid Doppler, transthoracic echo, transoesophageal echo. UNLESS there are extensive delays for testing >72 hour, negotiation should occur to enable patient transport back to Acute Service for further required testing.

3. Not dependent on inotropic or ventilatory support.

4. Stable level of consciousness (unless palliative).

5. Reliable route of nutrition and/or hydration (NG Tube, PEG Tube and IV line). Ensure the referral service is able to care for patients with these insitu.
3. Protocol for Transfer of Care for MIMICS when diagnosis not Stroke

- This protocol is for FAST positive patients who have been transported to a Acute Stroke Thrombolysis Service but have not had an acute stroke
- Stroke mimics include, migraine, psychosomatic, brain tumour, drug induced symptomology (as per national Stroke Research Institute stroke audit tool)
- Stroke mimics should be discharged directly from the Emergency Department, Acute Stroke Thrombolysis Unit or Acute Stroke Unit, where possible
- Stroke mimics who cannot be discharged directly home should be repatriated within 24 hours of a non-stroke diagnosis being made, to the patients local hospital or transferred to a clinical service or ward, if clinically appropriate
4. Protocol for Transfer of Care – Rehabilitation Post Stroke

- This protocol is for FAST positive patients who have been admitted to an Acute Stroke Thrombolysis Service

Start from Acute Stroke Thrombolysis Service

Is the patient medically stable?

YES

Transfer to appropriate Clinical Service

NO

Remain in Acute Stroke Thrombolysis Centre

Medically Stable for Transfer to appropriate Clinical Service

1. Clear diagnosis of stroke & secondary prevention plan
2. Appropriate investigations should be completed prior to referral if they are not accessible at the receiving hospital Eg. Carotid Doppler, transthoracic echo, transoesophageal echo
UNLESS there are extensive delays for testing >72hour, negotiation should occur to enable patient transport back to Acute Service for further required testing
3. Not dependent on inotropic or ventilatory support
4. Stable level of consciousness
5. Reliable route of nutrition and/or hydration(NG Tube, PEG Tube and IV line). Ensure the referral service able to care for patients with these insitu

Suitable for Rehabilitation

On Site Rehabilitation

Co-Located Rehabilitation

Not suitable for Rehabilitation

Off site Rehabilitation

Adjacent Rehabilitation

Not needing Rehabilitation

Appropriate Plan of Management documented

Now

Ever

Acknowledgement to Rehabilitation Leaders Forum-10 February 2012
NSW Health Policy Directive

PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals

PD2011_031 Inter-facility Transfer Process for Adults Requiring Specialist Care

PD2011_015 Care Coordination: Planning from admission to Transfer of Care in NSW public hospitals

GL2008_018 CPR-Decision relating to No Cardiopulmonary Resuscitation (this is current policy but will be replaced by Advance Planning for Quality Care at End of Life: Strategic and Implementation Framework still in draft form)

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