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Royal Cornwall Hospitals NHS Trust

Stroke Pathway
Standard Operating Procedure

V3.0

April 2023

Table of Contents

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

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Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

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Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. This SOP provides an overview of the Stroke Pathway at Royal Cornwall Hospital and will guide clinicians and managers in the care and treatment of acute stroke patients.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Standard Operating Procedure

2.1. To ensure clarity across all services and departments in relation to the acute stroke pathway, in line with national guidance1.

2.2. Bring together all the documents relating to the Acute Stroke Pathway that the Trust currently works to.

2.3. Identify the roles and responsibilities of all those involved in the pathway.

2.4. Used in the training, development and annual appraisal of staff directly working in the Acute Stroke Pathway.

3. Ownership and Responsibilities

3.1. Southwest Ambulance Foundation Trust (F.T)

- Respond to 999 calls.
- Identify suspected Stroke using the SWASFT guideline.
- Pre-alert RCH Emergency Department (ED) using ATMIST.
- Transport patient as emergency to RCH ED, and direct to CT Scan.
- Hand over patient to the Rapid Assessment Team and Stroke Specialist Nurse.

3.2. Emergency Department Team

- ED Nurse Co-ordinator receives ATMIST information about suspected stroke patient from SWAST.
- ED Nurse Co-ordinator alerts Acute Stroke Team (Stroke Specialist Nurse, Radiographer and site co-ordinator) using 4444.
- ED Nurse Co-ordinator asks Doctor to request CT Head Scan or ‘Stroke CT (includes CT head and CT angiogram) if symptom onset within last 24 hours and patient had good functional baseline.
- Patient is taken direct to CT scan by ambulance crew unless the patient requires resuscitation.
- ED Receptionists receive patient details from ambulance crew and book them in as suspected stroke – including patients that are medically expected.

- Patient returns to Resus Room from CT scan unless thrombolysis and emergency BP control have been excluded.

- Resus Room nursing team and Stroke Specialist Nurse perform the initial assessment and enter triage details on to Oceano / Nervecentre.

- If need for thrombolysis and emergency BP control are both excluded before return from CT, then the patient may instead be received by the Majors Triage Nurse and Rapid Assessment Team for triage and initial assessment.

- Initial Assessment will include, as per Acute Stroke Management Guideline (3):

  a. Observations, ECG, Bloods, cannulation, Swallow screen.

  b. NEWS score

  c. Triage category of S3 until thrombolysis and emergency BP control have been excluded.

- ED Consultant and/or Middle Grade assess patient for potential thrombolysis or thrombectomy treatment, following the thrombolysis protocol (4).

- ED Consultant prescribes thrombolysis treatment or refers for thrombectomy treatment.

- ED Team updates Oceano with potential stroke diagnosis and outcome (i.e., Admittance to ward or discharge to TIA clinic). If the patient is not Thrombolysed, and does not require emergency BP control for haemorrhage, they are graded S2 and Oceano updated, unless they are critically unwell. Thrombolysed patients or those requiring emergency BP control remain at S3.

- ED Team to follow Hyperacute Stroke Protocol – Thrombolysis and Mechanical Thrombectomy Clinical Guideline for close observation and treatment of complications (4).

- If the patient has failed the swallow screen, patient should be ‘nil by mouth’ and intravenous fluids commenced.

- Patient is clerked by an ED doctor, with assistance from the Stroke Specialist Nurse.

- Clinicians provide patient and family with information about potential diagnosis and treatment.

- ED receptionists make up patient notes and scan onto Maxims.

- Admitting doctor to review CT Scan report and action appropriately. Prescribe 300mgs Aspirin for ischaemic stroke as per the Acute Stroke Management Guideline (2).

- Observe thrombolysed or haemorrhagic stroke patients for hypertension and follow the Management of Hypertension following intracerebral haemorrhage Guideline (5).

- Patients presenting with one episode of non-disabling symptoms that resolve must be referred to the TIA clinic on Oceano GP letter. If the patient has been discharged from Oceano (e.g., is in CDU), referral to TIA clinic is by email to cornwalltiaclinic@nhs.net including patient identifiers, clinical picture and contact details. Two or more episodes of resolving symptoms should continue on the Acute Stroke Pathway (as "crescendo TIA"). If symptoms are not suggestive of TIA, consider discussion with Eldercare consultant via Silverphone.

- Admit patient direct to the Hyperacute Stroke Unit (HASU) within 4 hours of arrival time (4).

- Patients who meet criteria for Stroke SDEC (Appendix 3) can be referred to the Stroke Nurse.

- ED team or stroke nurse to enter all stroke admissions afterhours (Mon-Fri after 1700 to 0800 following morning, and on weekends/public holidays) to 'On take' system to facilitate post take ward round/senior review.

3.3. Stroke Nurse Specialist Team

- Liaise with ward to identify bed on the Hyperacute Stroke Unit (HASU).

- Assist ED Team to assess for potential thrombolysis treatment

- Administer Thrombolysis treatment if it has been prescribed.

- Follow Hyperacute Stroke Protocol – Thrombolysis and Mechanical Thrombectomy Clinical Guideline (4) for close observation and treatment of complications.

- Complete Stroke Specialist nursing documentation.

- Complete Capture Stroke data collection.

3.4. Acute Stroke Ward

Assessment of patient undertaken by all team members within 24 hours as per Acute Stroke Guideline and Stroke Multi-Disciplinary Care Pathway. Individual Team roles detailed below.

3.4.1. **Acute Stroke Ward Nursing Team**

- Assess patient as soon as they arrive on the ward and complete observations.

- Complete risk assessments within 12hours of admission.

- Formalise plans of care as required.

- Work alongside MDT to deliver individualised care.
- Alert Acute Stroke Medical Team.
- Provide Stroke Information Pack, if not already provided.
- Liaise with relevant community team regarding discharge/transfer.
- Liaise with pharmacy and provide medications for discharge.
- Ensure discharge summary is completed.
- Ensure 'ready to leave' tab completed to notify GP of discharge.

3.4.2. **Escalation of Medically Unwell Patient:**

- In hours- nurse contact junior doctors' team on ward, if no response within 10 minutes contact stroke consultant am, pm eldercare consultant on duty.
- Out of hours and weekends: bleep junior doctor if no response within 10 minutes contact registrar. If emergency use emergency bleep procedure.

3.4.3. **Acute Stroke Medical Team**

- Stroke or on-call Eldercare Consultant reviews patient at earliest opportunity, at a maximum with 14 hours of admission to the hospital and instigate investigations and management as per Acute Stroke Guideline and Secondary Prevention Guideline1.
- Medical Team complete the Stroke Proforma including the National Institute of Stroke Scale (NIHSS) if not already completed in ED on admission, and at 24 hours.
- Arrange investigations, treatment and discuss diagnosis, management and care plan with patient and their relatives.
- Provide Stroke Information Pack, if not already provided.
- Attend twice daily board rounds on weekdays and update team members on clinical information.
- Identify Expected Date for Discharge for patient and discharge destination.
- Medical team complete E-Discharge Summary for all patients before they leave the ward.

3.4.4. **Lead Stroke Consultant:**

- Reports in the ED and the Eldercare Governance and Business Meetings, and the Stroke Operations Meeting stroke thrombolysis outcomes monthly and key performance indicators.

- Monthly meeting with Clinical Coding Team to ensure appropriate allocation of stroke diagnosis. Update Clinical Guidelines as needed.

- Investigate Serious Incidents and complaints that occur in the Stroke Pathway in conjunction with clinicians and managers.

3.5. Radiology Team

- Unenhanced CT performed for initial assessment or Stroke CT (CT head and CT angiogram) if patient has good pre-stroke function and symptom onset within last 24 hours.

- Brain MRI brain scan may be considered upon the recommendation of a Stroke Consultant or Neurologist in the following circumstances: young strokes / TIA (<55 years); suspected posterior fossa strokes; suspected venous sinus thrombosis, diagnostic uncertainty.

3.6. Therapy Team

3.6.1. **Speech and Language Therapy Team:**

Communication

- People with communication The Speech and language therapy service will deliver at least 45 minutes of rehabilitation daily as per RCP guidelines (2016).

- Patients will be given the opportunity to practise their communication with a SLT or other communication partner as frequently as tolerated.

- Patients will be given the opportunity to practise their communication with a SLT or other communication partner as frequently as tolerated.

- The SLT will explain the nature and implications of the communication disorder to the person, their family/carers and the multidisciplinary team.

- Communication partners (e.g., family/carers, staff) of a person with severe communication difficulties after stroke will be supported in how to assist the person with their communication.

- Commence early rehabilitation until transfer or discharge with ESD or all until all goals have been achieved.

- The SLT team will work collaboratively with the rest of the MDT in the patient's best interest.

- Advise MDT to list for further inpatient rehabilitation by informing the nurse in charge.

- To advise MDT to discharge home with ESD as part of collaborative MDT decision making process. To check ESD capacity and complete electronic ESD form and email referral the day the patient is discharged to be seen by ESD the next working day.

Difficulty Swallowing-Dysphagia

- After acute stroke patients identified to have dysphagia should have a comprehensive assessment of their swallowing by a specialist in dysphagia management including videofluoroscopy or fibreoptic endoscopic evaluation of swallowing if indicated.

- Patients with dysphagia will be considered for swallow rehabilitation including compensatory strategies and sensory and texture modification.

- Food, fluids and medications should be provided in a form that can be swallowed without aspiration.

- Nasogastric tube (NGT) feeding should be considered within 24 hours if unable to swallow safely, and gastrostomy feeding should be considered if unable to tolerate NGT feeding or unable to swallow adequate food and fluids safely by four weeks from the stroke onset.

- Written guidance for all staff/carers to use when feeding or providing fluids will be provided.

- People with stroke receiving end-of-life (palliative) care should not have burdensome restrictions imposed on oral food and/or fluid intake if restrictions would exacerbate suffering.

- Commence early rehabilitation until transfer or discharge with ESD or all until all goals have been achieved.

- Advise MDT to list for further inpatient rehabilitation by informing the nurse in charge.

- To advise MDT to discharge home with ESD as part of collaborative MDT decision making process. To check ESD capacity and complete electronic ESD form and email referral the day the patient is discharged to be seen by ESD the next working day.

3.6.2. **Physiotherapy:**

- Patients who are clinically stable will have a neurological assessment by a physiotherapist within 24-48hrs of stroke onset, Monday to Saturday.
- Assess motor and sensory function, tone, coordination, as well as functional assessment of sitting and standing balance as appropriate.
- Advise on safest method of transfer out of bed recommending appropriate equipment and seating.
- Complete a mobility assessment and patients will be trained in how to use appropriate mobility aids including a wheelchair to enable safe independent mobility.
- Assess risk of falls, including assessment of fear of falling, using appropriate standardised outcome measures. People at high risk of falls after stroke will be encouraged to participate in physical activity/exercise incorporating balance and coordination exercises.
- Assess patients with compromised respiratory function or those following aspiration and treat respiratory complications accordingly.
- Advise on positioning of patient to minimise the risk of aspiration and other respiratory complications, shoulder pain and subluxation, contractures and skin pressure ulceration.
- Assess tone/spasticity, the need for anti-spasticity medication and use of splinting in collaboration with the MDT.
- Assessment for orthoses and interventions to improve gait.
- Formulate problem list, patient-centred SMART goals and treatment plans.
- Deliver at least 45 minutes of rehabilitation daily as per RCP guidelines (2016).
- Advise MDT to list for further inpatient rehabilitation by informing the nurse in charge.
- To advise MDT to discharge home with ESD as part of collaborative MDT decision making process. To check ESD capacity and complete electronic ESD form and email referral the day the patient is discharged to be seen by ESD the next working day.
- Commence early rehabilitation to include task specific, repetitive, intensive exercises and activities until transfer or discharge with ESD or all until all goals have been achieved and Physiotherapy is no longer required.

3.6.3. **Occupational Therapy:**

- Will be assessed by an Occupational Therapist within 72hours of admission.
- Assessment of motor, sensory, vision, perception, cognition and mood post stroke.
- The Occupational Therapist will provide a treatment and rehabilitation plan dependant on stroke deficits.
- Routine screening to identify functional level pre and post stroke.
- Assessment, provision and training in the use of equipment and adaptations to increase independence.
- Assessment of pre-stroke work and leisure activities.
- To use standardised measures to assess cognition and mood post stroke as per RCP guidelines.
- Deliver at least 45 minutes of rehabilitation daily as per RCP guidelines.
- To promote independence in a safe and supported way on the ward for duration of admission.
- Provide opportunities to practice upper limb movement in functional activities.
- To advise and support positioning and splinting provision and care plans.
- Occupational Therapy referral at rapid round at 0830hrs Monday to Saturday.
- To advise MDT to list for further inpatient rehabilitation by informing the nurse in charge.
- Commence early rehabilitation until transfer or discharge with ESD or all until all goals have been achieved.
- To support discharge planning from the acute stroke unit by completing the appropriate signposting and referrals to onward services.
- To advise MDT to discharge home with ESD as part of collaborative MDT decision making process. To check ESD capacity and complete electronic ESD form and email referral the day the patient is discharged to be seen by ESD the next working day.
- The Occupational Therapy team will work collaboratively with the rest of the MDT in the patient's best interest.

3.6.4. **Dietician:**

- All patients admitted with acute stroke should be screened for risk of malnutrition on admission and at least weekly thereafter using the MUST screening tool.

- All patients identified as high risk should be referred to the Specialist Stroke Dietitian for assessment, advice and monitoring – this includes all patients requiring artificial nutrition or dietary modification (including diet/fluids of modified consistency).

- Referrals will be received at morning rapid round Monday-Saturday. In the absence of a Dietitian referrals should be made via Maxims.

- Patients who are unable to maintain adequate nutrition and fluids orally should be referred to the Specialist Stroke Dietitian for assessment, advice and monitoring.

- Nasogastric tube (NGT) feeding should be considered within 24 hours if unable to swallow safely, and gastrostomy feeding should be considered if unable to tolerate NGT feeding or unable to swallow adequate food and fluids safely by four weeks from the stroke onset.

- Specialist Stroke Dietitian will be available to advise and support the MDT on the appropriateness of using nasogastric fixation devices, and gastrostomy placement.

- Specialist Stroke Dietitian will work alongside the MDT in providing information and counselling to patients and/or families of patients requiring gastrostomy placement.

- Specialist Stroke Dietitian will advise MDT to discharge home with ESD as part of collaborative MDT decision making process.

- All patients requiring ongoing monitoring and advice following discharge will be referred to the appropriate dietetic community service.

- All patients admitted with acute Stroke will be provided with up-to-date dietary secondary prevention advice via an evidence-based information leaflet. Further education will be provided where time allows at community Stroke Rehabilitation units.

3.7. Data Collection:

- Data collection starts by the Acute Stroke Specialist Nurse at the beginning of the pathway and throughout the pathway via Capture Stroke data collection system.

- Data Collector collates information, liaises with the clinicians, Ward Manager and Clinical Admin Lead to produce accurate report.

- Clinical Admin Lead co-ordinates and distributes the weekly Exception Report.

- Data results are reviewed on RADAR and daily board round at 15:00. Monthly review at stroke operational group meeting and quarterly review of SSNAP results.

3.8. Vascular Studies:

- All Patients with an Ischaemic Stroke or TIA will be considered for a duplex of the neck arteries if they are fit for surgery. Duplex US scan is not required if patient already had a CT angiogram/Stroke CT scan, unless patient is candidate for carotid surgery (in which case two-imaging modalities are required to facilitate Carotid MDT decision-making regarding surgery).

- Investigation is completed within 24 hours of request.

3.9. Early Supported Discharge (ESD Team):

Patients on the ward are assessed for referral to the ESD Team at the earliest opportunity, when the following criteria are met:

- Patient is over the age of 18.

- Patient has a new clinical diagnosis of stroke via consultant or CT.

- Patient is being discharged from acute or rehabilitation inpatient stroke setting, including Stroke SDEC, or other clinical settings such as ED/MAU/TIA clinic if the patient has been seen by or discussed with Stroke/Phoenix therapy team.

- Patient requires stroke specialist intensive OT and/or SLT and/or Physiotherapy more Patient can transfer independently or with assistance of one, with or without an aid (stick/crutch/tripod/frame) – please see information below for other equipment.

- Patient and carer have consented to ESD.

- Home environment has been risk assessed and risks for discharge minimised.

- Patient has risks minimised between carer visits or has family members present to mediate risks.

- Patient is able to reliably make basic needs known (including reliable yes/no) to all members of inpatient staff and relatives / carers (with or without the aid of a communication chart).

- Patient has established dietary routine which can be managed by community services if required (oral and/or PEG).

- See the patient within 24 hrs of the referral except at weekends.

- Assessment of cognition and mood is conducted by Occupational Therapists in the Acute setting in line with RCP Stroke guidelines.

- Stroke ESD team are contacted to check capacity and basic patient details provided.

- An electronic referral is emailed, and patient provided with ESD information sheet.

- All data of therapy assessment, rehabilitation and discharge is recorded in paper format and on Capture Stroke and Capture Therapy data base.

3.9.1. Patients transferring with Sara Stedy, Mo-lift or Return are not routinely seen by ESD currently and are accepted onto the caseload on a case-by-case basis. When planning discharges for patients using these pieces of equipment, in addition to the exclusion/inclusion criteria above and normal environmental considerations the following is recommended.

- Any patient transferring with this equipment – should be clearly expected to progress to a walking aid (and be able to transfer with assistance of 1) within 4 weeks.

- Patients should be using the pieces of equipment regularly within the hospital environment.

- The home environment should be suitable to safely continue therapy to progress mobility.

- Inpatient therapists should discuss each individual patient with the ESD Stroke Team Lead/Qualified member of staff within the ESD Stroke team.

- Current ESD staffing levels and caseload will determine whether the patient can be safely accepted to the ESD caseload.

3.10. Community Stroke Rehab Units (Camborne and Redruth Hospital with 23 beds and Bodmin Hospital with 8 beds):

- Patients are identified by the clinical team at the board rounds when they are suitable and fit for transfer to the Rehab Unit.

- Nursing staff list patients for Rehab Unit as per the Stroke Multi-Disciplinary Care Pathway.

- All patients transferring to the Rehab Unit must have an E-Discharge summary.

3.11. Community Stroke Team:

All patients have a follow up meeting with the Community Stroke Nurse Co-ordinator at 1 month and 12 months post discharge.

3.12. TIA Clinic Service:

- Any patient with transient neurological symptoms should be referred to the daily TIA clinic via email to cornwalltiaclinic@nhs.net
- All patients are reviewed in the TIA clinic within 24 hours of referral. If the suspected TIA occurred more than 1 week ago the patient should be assessed as soon as possible within 7 days.

3.13. Stroke Research:

Patients are screened for research trials and offered opportunity to take part if eligible by stroke research team (contact extension 6422).

4. Standards and Practice

All staff involved in the care of stroke patients will familiarise themselves with the stroke guidelines on the RCHT Intranet pages by using the following link:

http://www.royalcornwall.nhs.uk/documentlibrary/clinicalguidelines/key-guidelines/

5. Dissemination and Implementation

5.1. Key staff teams have been consulted on the Stroke Pathway.

5.2. Distribution:

5.2.1. This SOP will be distributed in hard copy to all areas that are part of the Stroke Pathway.

5.2.2. This SOP will be available to view on the following link:

http://www.royalcornwall.nhs.uk/documentlibrary/clinicalguidelines/key-guidelines/

5.3. Training:

5.3.1. All clinical staff involved in thrombolysis will undertake the e-learning module training through the Learning and Management Website – ESR. Training for the NIHSS is web based and details can be accessed through the Stroke Thrombolysis Protocol.

5.3.2. All clinical staff involved in the care of Stroke Patients familiarise themselves with the core stroke competencies available on the Stroke Training and Awareness Resources (STARS) website at the following link: http://www.strokecorecompetencies.org/node.asp?id=home

5.3.3. All staff are encouraged to participate in national and local Stroke meetings and network conferences. It is the aspiration of the RCHT to host a yearly Stroke conference to showcase achievements and developments in Stroke Improvements.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Stroke Pathway
Lead	Stroke Lead Consultant and Directorate Manager
Tool	Capture Stroke Data Collection SSNAP Audit Weekly Exception Reporting
Frequency	Monthly
Reporting arrangements	• Stroke Operational Meeting • Stroke Executive Group • Weekly interrogation of the Stroke Pathway to identify where the pathway has not been followed, why and how it will be prevented from happening again.
Acting on recommendations and Lead(s)	Stroke Operational Group Stroke Execs Group Leads: • Lead Stroke Consultant Mohana Maddula • Directorate Manager Nigel D'Arcy • Clinical Matron Emma Bellamy • Ward Leader Natalie Keogh
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within the timeframe agreed by the Stroke Operational Group. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

7. Updating and Review

This Standard Operating Procedure will be reviewed in line with changes to the guidance as worded before.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Stroke Pathway Standard Operating Procedure V3.0
This document replaces (exact title of previous version):	Stroke Pathway Standard Operating Procedure V2.0
Date Issued/Approved:	March 2023
Date Valid From:	April 2023
Date Valid To:	April 2026
Directorate / Department responsible (author/owner):	Emma Bellamy, Clinical Matron Older People's Services and Stroke
Contact details:	01872 252019
Brief summary of contents:	This standard operating Procedure provides an overview of the Stroke Pathway at Royal Cornwall Hospital and will guide clinicians and managers in the care and treatment of acute stroke patients.
Suggested Keywords:	Stroke, Standard Operating procedure
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Care Group Governance Meeting
General Manager confirming approval processes:	Johanna Floyd
Name of Governance Lead confirming approval by specialty and care group management meetings:	Paul Evangelista
Links to key external standards:	none required

Information Category	Detailed Information
Related Documents:	Intercollegiate Stroke Working Party. National Clinical Guidelines for Stroke 2016. 5th edition. Royal College of Physicians. NICE. Stroke and TIA in over 16s diagnosis and initial management. NG 128. 2019. RCHT: Acute Stroke Management Guideline 2019. Intranet RCHT: Hyperacute Stroke Protocol Thrombolysis and Thrombectomy Guideline 2020. V11.1 Intranet RCHT: Management of Hypertension in Haemorrhagic stroke 2018. Intranet RCHT: Multidisciplinary Stroke Pathway 2019. Intranet
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Stroke

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
February 2020	V1.0	Initial issue	Emma Bellamy, Clinical Matron Older People's Services and Stroke
November 2020	V2.0	Update with information about CT and CTA pathway and ED and stroke nurse responsibilities	Emma Bellamy, Clinical Matron Esther Penrose, Head of Nursing, K Adie, Stroke Consultant
March 2023	V3.0	Full Update	Emma Bellamy, Clinical Matron Older People's Services and Stroke

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Stroke Pathway Standard Operating Procedure V3.0
Directorate and service area:	Acute Stroke Service
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be ompleted by an individual with a good understanding of the Service/Policy):	Emma Bellamy, Eldercare Matron
Contact details:	01872 252019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	The aim of this policy is to define the Stroke Pathway
2. Policy Objectives	The objectives of this policy are: • Identify the roles and responsibilities of the people involved in the pathway. • Detail processes to monitor the effectiveness of the pathway.
3. Policy Intended Outcomes	Ensure the Stroke pathway works effectively, safely and improve the experience of patients who have had a stroke.
4. How will you measure each outcome?	There is an established Stroke Key Performance Dashboard which is reviewed monthly at the Stroke Operational Meetings. The Dashboard is monitored on a weekly basis and an exception report prepared to ensure breaches to the targets are investigated and lessons learned.

Information Category	Detailed Information
5. Who is intended to benefit from the policy?	Patients who have had a stroke.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** SWASFT, ED, Acute Stroke Ward, Acute Stroke Physicians, Older Persons Physicians, Therapy Teams – SALT, OT, PT, Dieticians, Data Collection, Vascular Studies, Radiology, Early Supported Discharge Team, Community Stroke Rehab, Community Stroke Team, TIA Clinic, Stroke Research, Medical Services Management team, Stroke survivors/patients.
6c. What was the outcome of the consultation?	Approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys: Yes**

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	Stroke can affect any person regardless of age.
Sex (male or female)	No	Stroke can affect any person regardless of gender.
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	Stroke can affect any person regardless of gender.
Race	No	Stroke can affect any person regardless of ethnic background.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Stroke can affect any person regardless of disability.
Religion or belief	No	Stroke can affect any person regardless of religion.
Marriage and civil partnership	No	Stroke can affect any person regardless of marital/civil partnership status.
Pregnancy and maternity	No	Stroke can affect any person regardless of whether they are pregnant.
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	Stroke can affect any person regardless of sexual orientation.

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Emma Bellamy, Eldercare Matron

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Stroke Same Day Emergency Care (SDEC)

Purpose

To provide ambulatory stroke multidisciplinary care for patients with acute stroke who have minimal or no significant disability.

Inclusion criteria	Exclusion criteria
• Patients with minor stroke. • (NIHSS <6). • Functionally: Able to transfer with one. • CFS <5.	• Patients with severe aphasia. • Severe dementia. • New requirement of assistance of 2 with personal care. • New confusion/delirium.
Patients from RH/NH to be considered on individual basis	

Proposed new pathway