ReAcT (Why do patients with stroke not receive the recommended amount of active therapy?)

Findings from one of the stroke units in the ReAcT study which were used in expert consensus meetings to promote discussion about different ways the therapists' day can be organised to increase available time for therapy provision.

Context: The stroke unit highlighted is a 24-bedded unit in a large district general hospital in South Yorkshire, offering a hyper-acute and acute stroke service. Length of stay is lower than the national average (mean = 13 days). After receiving initial care in the unit patients can be discharged directly home, discharged home with early supported discharge team input or transferred to one of two rehabilitation units in hospitals in the area.

The therapists' working day:

Occupational therapists (OTs) work shifts to cover the hours of 7am-4.30pm and physiotherapists (PTs) to cover 7.30am-5pm, Monday to Friday. Occupational therapists and physiotherapists cover weekends 7am-3pm/8am-4pm. Speech and language therapists (SLTs) are based on the stroke unit and work from 8am-4pm Monday to Saturday. The therapists' day is timetabled into hourly slots between 7am-12pm and 12.30-5pm, with the aim of having 45 minutes direct contact and 15 minutes for record-keeping and preparation. Two patients may be timetabled into one slot if a shorter session is required. Patient protected mealtimes run from 12-12.30pm and therapists stagger their lunch breaks between 12-1.30pm with some providing direct meal support for patients during protected meal times.

Meetings and handovers

☐ One PT attends a daily handover with a nurse each morning for 10-15 minutes (at 7.30am) and then updates a patient summary whiteboard and completes a daily timetable for OT and PT staff. This takes an additional 15 minutes, so is normally complete by 8am. While the PT is engaged in handover and timetabling, OT staff will complete washing and dressing assessments and practice from 7am. The PT then gives a very brief handover to an OT regarding changes and anything which may influence the timetable or impact on planning. Any specific change information will be informally provided to the therapist timetabled to see the patient.

☐ A paper based nursing handover sheet is available to all therapists but there is no other formal handover activity between therapists. SLTs will be informed of any new patients/ specific changes affecting their patient care through this typed handover and brief informal checks with therapy or nursing staff when they start at 8am.

☐ An hour-long board round meeting takes place three times per week and is attended by one OT, one PT and one SLT, with a discharge co-ordinator. Two of these meetings each week are also attended by therapists from the stroke community teams. During these board rounds, one member of staff reads aloud the nursing handover, one updates each patients' goals sheet and one highlights patients eligible for discharge with ESD. The other therapists do not routinely participate in the board rounds.

☐ There are three stroke consultants working on the unit. Three Multidisciplinary team meetings take place each week, each lasting one hour. These are attended by one member of qualified staff from each discipline, a nurse and a consultant.

☐ Family meetings are rarely held, although meetings with medical staff are available for relatives.

This approach to the organisation of the therapists' day was quite different to that observed in the other stroke units in the ReAcT study and it is one example of how time spent in non-clinical activity could be reduced. In interviews with staff in this unit the study team explored whether therapists felt that they were not receiving sufficient information about patients to support their clinical decision-making in terms of the frequency and intensity of therapy. Those interviewed did not feel that was the case.

The stroke unit team developed a vision for their service and has worked consistently over a period of time to examine each aspect of the stroke pathway and determine areas for improvement. The team have used stroke audit data, and worked closely with hospital managers and the local CCG to drive service improvement. The example above focuses only on how the team manage the important processes of information exchange and multidisciplinary meetings to ensure that the amount of time therapists spend in non-clinical activities is kept to a minimum. The unit has been rated AAA for therapy provision (team-centred data from SSNAP domains 5-7) since April 2015 and has retained that performance level in each audit quarter since.

Other changes which have occurred in the service over time and which underpin the example above include:

- Increased awareness of and sharing of SSNAP results – looked for areas needed to improve. Reviewed in stroke pathway meetings and displayed results / circulated results.
- Improved the SSNAP audit sheets and examined how audit compliance could be improved, led to increased accuracy and consistency in recording therapy.
- Introduced daily board rounds at first with reduced number of attendees and new documentation to support (SBAR tool used and goal focused). Later reduced these to three times a week.
- Increased SLT establishment to meet Stroke Assurance Framework Guidance.
- Introduced 6 day SLT service.
- Introduced Therapy Team Lead Role.
- Introduced Stroke Pathway Clinical Manager role
- Introduced SLT band 3 assistant
- Introduced an MDT goal / planning board – communication board
- Duties / responsibilities specified and divided amongst therapy team (examples include named therapist responsible for ensuring outliers are assessed and received stroke specific therapy):
- Established a single, on unit therapy room – fostered team integration with greater SLT presence
- Participation in the Stroke Accreditation Process drew attention to specific aspects of service delivery and quality and led to focus on service development in these areas.