TASC Vignette

Thrombolysis in Acute Stroke Collaborative

Site Name: Lancashire Teaching Hospitals NHS Foundation Trust – Preston Hospital

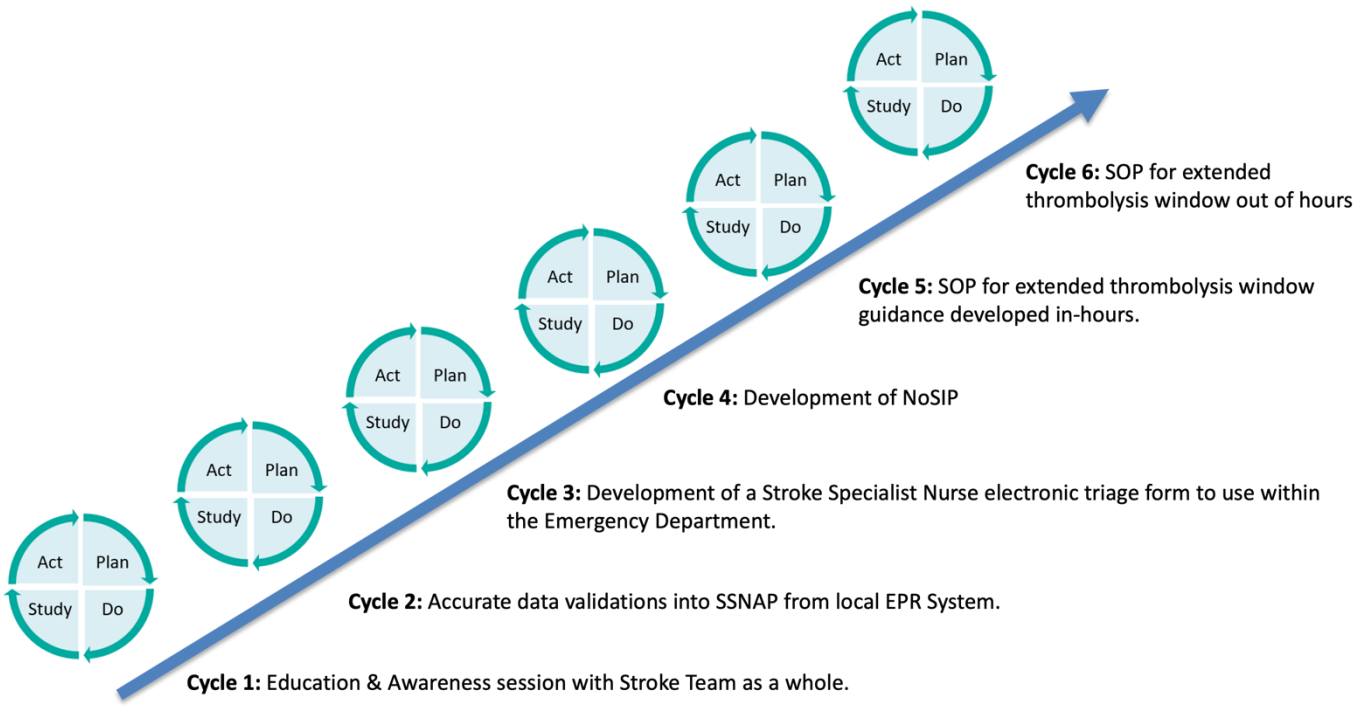
The TASC Principle: 1, 3, 6, 8

Our Challenge

We identified that there was room for improvement in both our thrombolysis rate and the efficiency of our patient pathway so that more patients received their treatment within 1hour. As a thrombectomy centre and a Major Trauma Centre we had some challenges around timely scans due to scanners being in use. We also had challenge from the delays and variation when using telestroke services out of hours with lower thrombolysis rates and slower scan to needle times.

What we did (the process)

Key to our success was applying a robust QI methodology and having a keen understanding of our data. This was an ethos shared throughout our clinical, operations and wider stroke team.

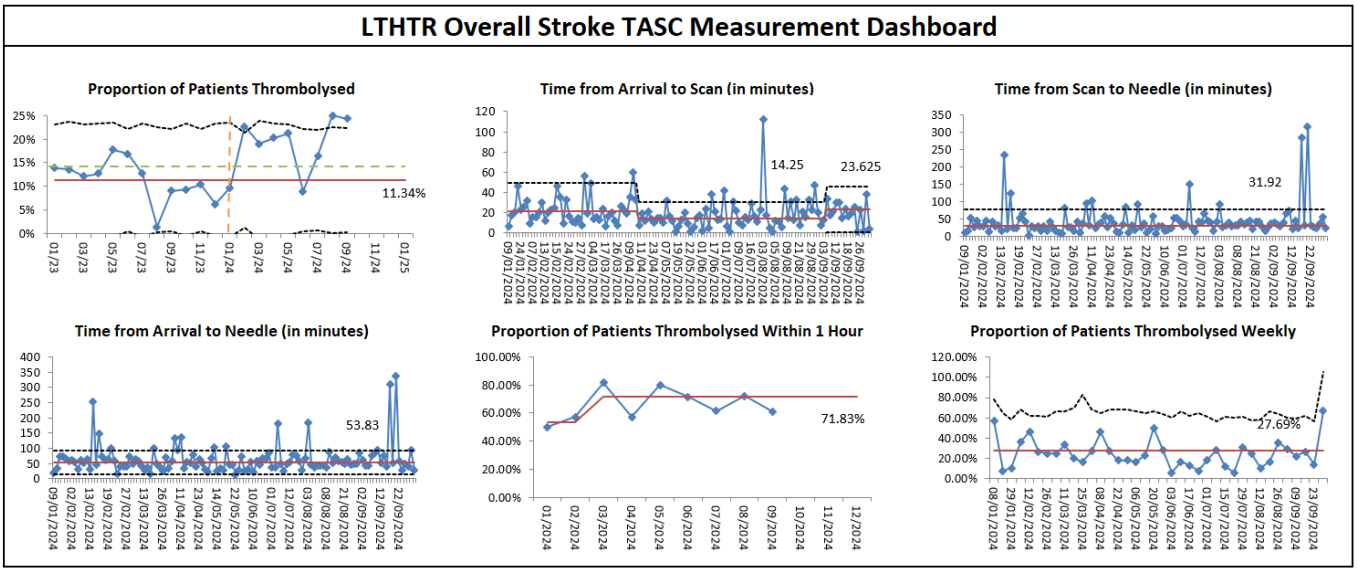


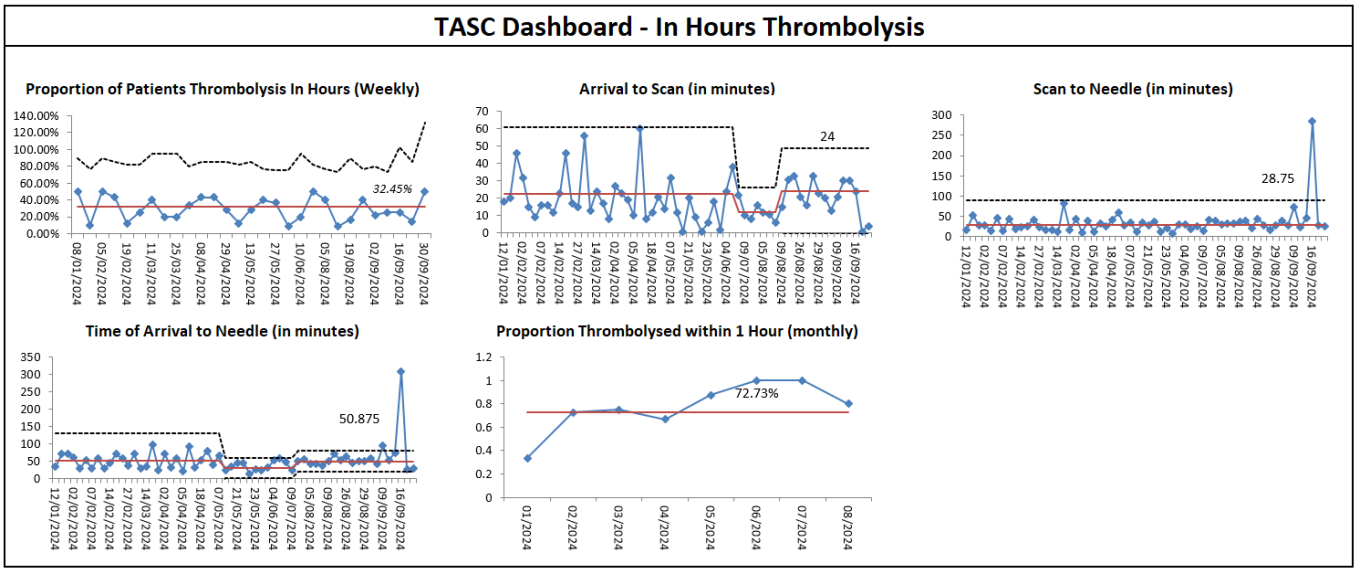
Our work focussed firstly on shifting the thrombolysis mindset around risk/benefit in less than 'ideal' patients. Simply bringing people together and talking about the issue seemed to make a rapid improvement in rates. Our Stroke Consultant Nurse targeted 'wake-up strokes' in particular and was able to shift behaviour away from discounting this patient group as ineligible to really interrogating the timing of onset and greater consideration of thrombolysis. Within this same domain of changing practise we also introduced our extended window thrombolysis in line with national guidance, which again required a mindset shift from clinical teams.

Further work was then around our processes and removing delays in our patient pathway. In particular we identified a significant admin burden for our stroke nurses with various parts of the system needing to be accessed and data duplication. We worked with our IT team to develop a rapid stroke proforma to streamline this process and improve our data capture.

What we achieved (the outcomes/data)

We saw significant improvement in our thrombolysis rates taking us repeatedly above the national average.





We also saw reductions in scan to needle time in our out of hours patients from 65min - 24min, in no small part due to our close work with the wider ISDN whose clinicians in other hospitals provide the telestroke service.

Key learning and further work

Learning

- 'Talking' about the 'problem' can just simply help.
- We have lots more work to do – opportunity is vast.
- Collaboration is the best way forward.
- Clinical / Nursing engagement is key.

Further work

- Continuing to tackle our Thrombolysis rates.
- Develop a process for reliably using the SAMuel testing platform.
- Combine our thrombolysis into our existing Stroke FCA Big Room.
- 4 LTHTR Stroke Workshops within November 24 to design our ‘perfect’ Stroke Service

Key system contacts

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