TASC Vignette

Thrombolysis in Acute Stroke Collaborative

Site Name: United Lincoln Teaching Hospitals – Lincoln County Hospital

The TASC Principle: 1, 6, 8

Our Challenge

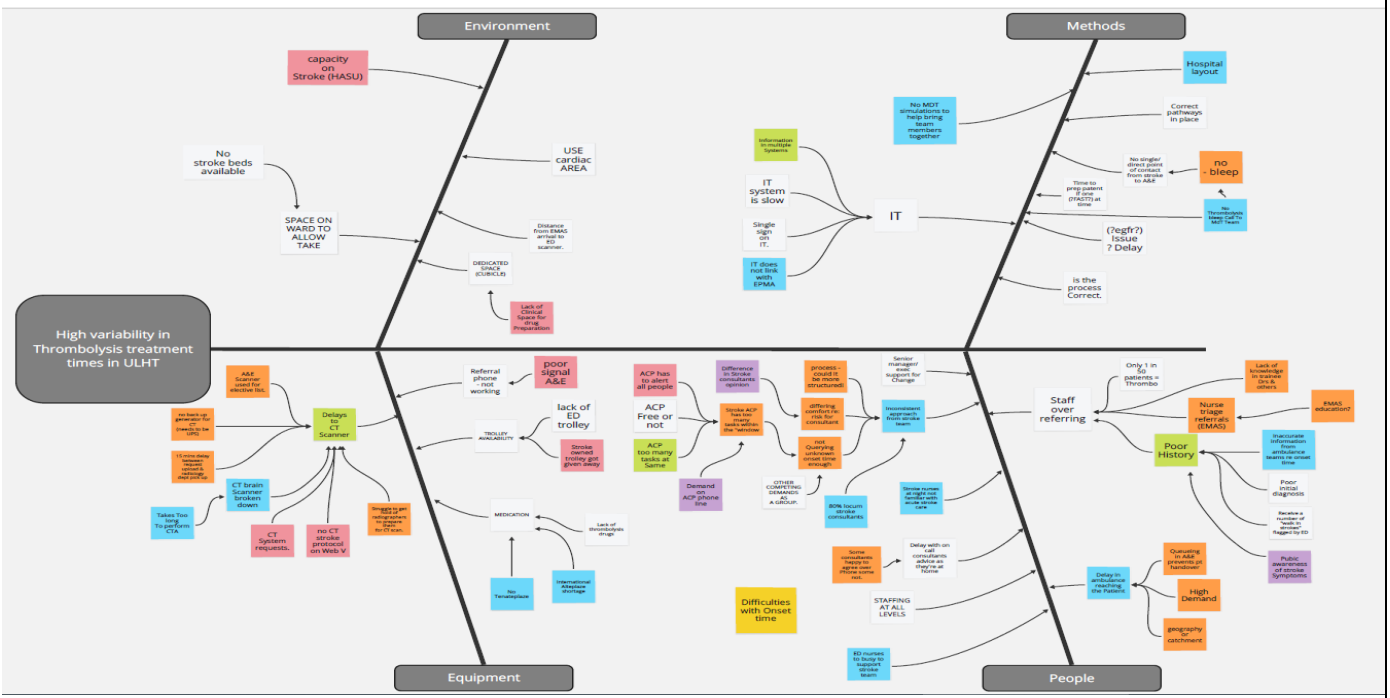
In common with other teams in the TASC programme we had struggled with lower than average thrombolysis rates sitting around 8% alongside delays in the patient pathway. We knew from previous pathway mapping work that we had undertaken, we experience delays due to limited space to assess our patients in the Emergency Department as well as one member of staff undertaking many tasks.

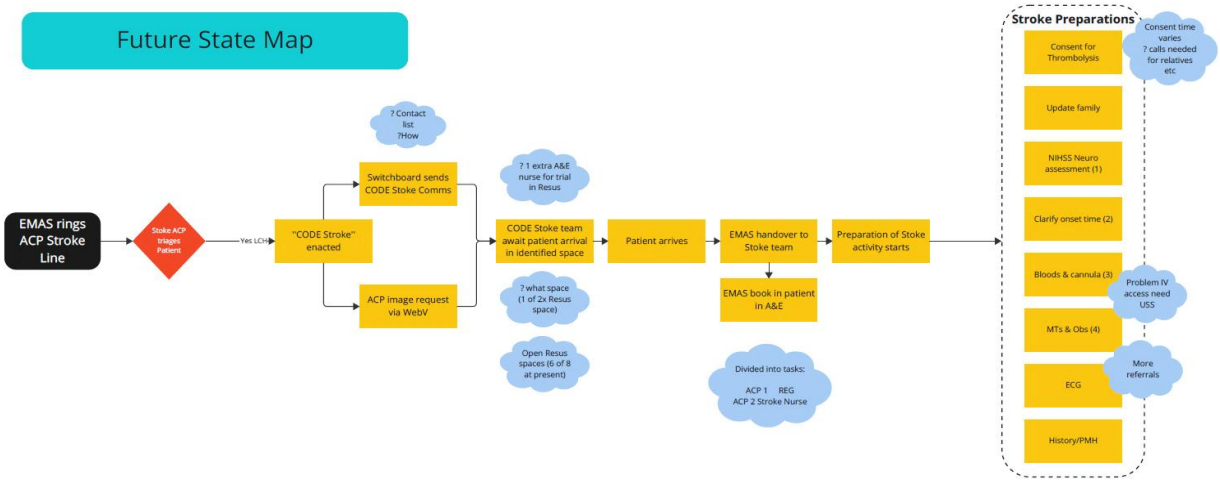
What we did (the process)

We spent time developing a good relationship with ED, a wider understanding of the need for rapid high quality care in thrombolysis and the impact this can have on downstream capacity. We also mapped the stroke patient pathway in ED to identify opportunities for improvements.

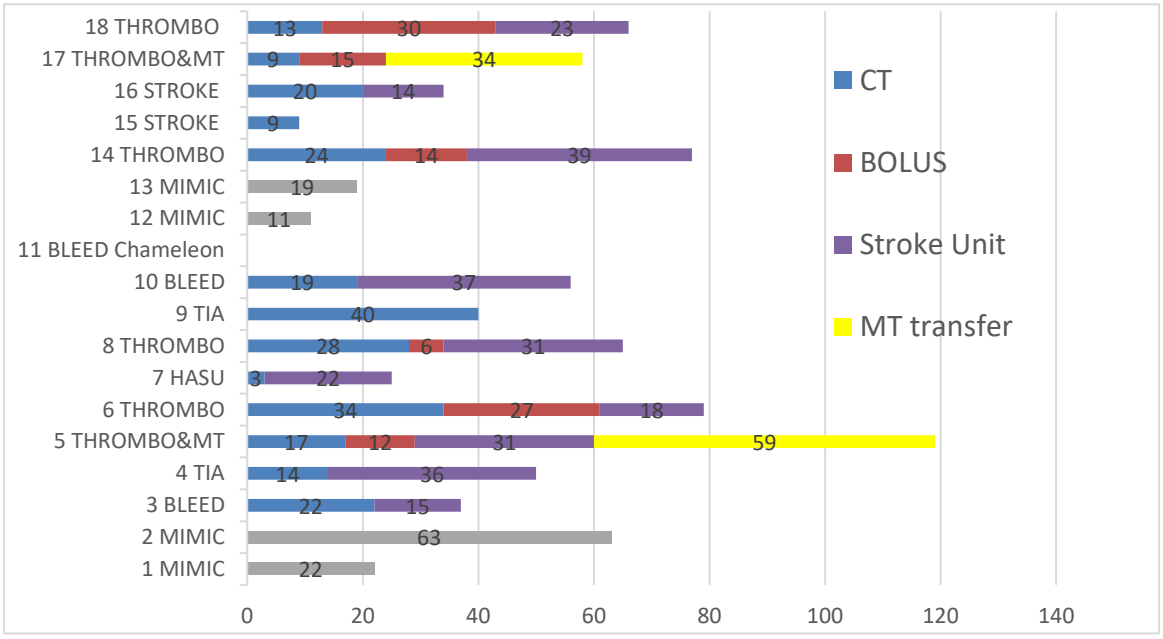
Our main piece of work looked at a 'Code Stroke' approach similar to the way a major trauma patient would be managed – the key principles being pre-alert, pre-arrival preparation, clear role definition for patient management, and the presence of all the required staff on patient arrival [stroke team.]. Our aim was to reduce the unwarranted variation in thrombolysis pathway, speed up treatment times and to reduce delays in decision making.

We also introduced regular thrombolysis patient pathway reviews to look into our decision making.





What we achieved (the outcomes/data)



- During our 'Code Stroke' PDSA we saw a significant **reduction in both our door to scan time and our door to needle time**.
- We saw benefits in increasing stroke awareness in the wider team and the opportunity to undertake informal training with junior stroke staff to **upskill and develop** them – this had the knock on effect of **improving morale and relationships**.
- **Patient flow in ED improved** as stroke patients were rapidly transferred to the stroke unit freeing up ED space.
- Our assessment times improved significantly and we hope to provide this data to the ambulance service in the hope to hold **ambulance crews while awaiting a potential decision to transfer to a thrombectomy centre.**

Over the duration of the TASC programme we saw **our thrombolysis rate increase from 8% to 12%**

Our next steps:

- Continue/embed Code Thrombolysis Team approach
- Ensure additional staff member support out of hours - [acknowledging increased Thrombectomy hours are imminent]
- Protect ring fenced HASU bed to reduce delays to HASU
- Allocation of RESUS space over Rapid Assessment Triage [RAT] space [as Resus was found to be quicker]
- Bolus in CT department not on Stroke Unit
- All members of the team to be present at patient arrival
- Ad-hoc audit of process
- Liaise with ambulance managers – add as VIZ AI user [app used to identify individuals for Thrombectomy] to allocate crew? Or hold original crew.

Key system contacts

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