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Steve Berry
Project and Website Administrator
NZ Guidelines Group
PO Box 10 665
Wellington

Dear Steve,

Re: Submission - Draft Stroke Guidelines Consultation

Thank you for the opportunity to review the draft guidelines. College members found this to be a good document and clearly a useful update on current practice. Almost all points of concern related to stroke in older people.

Key comments as below:

- Good support for education of staff.
- TIA guideline update is very clear and supports good practice.
- The document consistently mentions that quick access to hospital to initiate therapy is essential. However it does not mention that access to hospital for older people in residential care may also be important but that barriers may exist. This population group is often managed by a GP and referrals to hospital are not always seen as appropriate, or the general demeanour of GP and ambulance staff is that this group is already in care. Our view is that this group should have equal access, unless an Advanced Directive dictates otherwise. The document does not clearly identify that 'community care' includes people in care facilities.
- The effectiveness of dedicated stroke units is briefly noted (page 56) and the document mentions that NZ evidence is not readily available. However a team at Auckland University evaluated the rehabilitation services of the Wellington Masonic Villages Trust. This Trust (NGO) was contracted by the MoH and later the MidCentral DHB to pilot a slow stream rehabilitation service. This was a health care innovation using residential care as a community place to deliver integrated interdisciplinary rehabilitation services. This research may be helpful for future development of services.

  Source: Tate, N., Jorgensen, D., Parsons, J., and Parson, M. (2007) The Horowhenua slow stream rehabilitation programme, Masonic Villages Trust, Wellington, 139pp,

- Platelet therapy is an important component of after stroke management, however access to lab services is not consistent throughout the country, hence that service may need to be flexible to ensure this can be accessed through other community care practices. Access and transport is an ongoing barrier for older people especially to access health care.

- Page 80 notes end-of–life issues and EPOA to be discussed. Ideally, this should be arranged before palliative care is indicated. EPOA is far more cumbersome to sort once a person is cognitively impaired. In practice, there is ongoing debate to have Advanced Directives and EPOA sorted long before a person becomes ill.

- Page 112, Pyrexia management, both the Dippell (2003) and DenHertog (2009) studies mentioned on page 112-113, noted that inclusion criteria for these studies was for patients over 18, but there was no report on how older people (over 65) were to be managed. The focus was to reduce pyrexia to have a better stroke outcome. Temperature in older people is not a reliable indicator and evidence on how to monitor this for older people should be included.

- Page 201, OT involvement in the community appears sensible, there are also Diversional therapists who could participate in community teams.

- Polypharmacy is an issue especially for older people who may already be on a variety of 'guideline recommended medications' as well as other medications they may be taking. This is an economic as well as a person specific issue. In clinical practice (although not widely evidenced in literature) one finds patients who are taking a large number of medications and the added medicines that they should take according to the guideline would create a range of serious potential side effects.

- In those cases a discussion is to be had with the patient (if possible) or the multi disciplinary team and risks of further stroke balanced against risk of medication side effects.

Yours Sincerely

Professor Jenny Carryer
Executive Director
(On behalf of the College of Nurses Members)