Memorandum

To: Regional Stroke Networks

From: The National TIA Working Group

Date: 27 November 2012 – updated 3 July 2013

Re: Standards for Regional TIA Clinical Pathways in New Zealand

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Dear Colleagues

1 Background

1.1 It is now four years since the publication of the New Zealand Guideline for the assessment and management of people with a recent transient ischaemic attack (TIA)[1]. The 2010 New Zealand Clinical Guidelines for Stroke Management confirmed the recommendations in the 2008 TIA Guideline.

1.2 Stroke is a leading cause of death and the major cause of long term adult disability in New Zealand. TIA is defined as stroke symptoms and signs that resolve within 24 hours ***and is a medical emergency***. Recent evidence highlights that the risk of stroke following TIA can be high, especially in the first 48 hours. Strokes that follow a TIA are not minor; one in five are fatal and a further two thirds are disabling.

1.3 Reorganisation of services to facilitate prompt treatment of people with TIA can prevent disabling strokes. Based on a generally accepted figure of $50,000 per new stroke in direct health costs in New Zealand, a relatively low number of strokes need to be prevented to justify intensification of services for people with TIA.

1.4 The most recent Stroke Foundation National Acute Audit of Stroke Services found that New Zealanders currently do not have sufficient access to organised acute stroke services and only eight out of 21 DHBs provided stroke services theatre consistent with international best practice.

1.5 The standard for any TIA *clinical pathway* in New Zealand is set out below, as a guide for Regional Stroke Networks, DHBs and clinicians. This is based on the New Zealand Clinical Guideline. While it is recognised that different regions will implement their TIA pathway in slightly different ways according to available resources, the National TIA Project Group, with representatives from all the regional stroke networks, has agreed that all TIA pathways should be based on the New Zealand Guideline.

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[1] New Zealand Guideline for the Assessment and Management of People with a Recent Transient Ischaemic Attack (TIA). Stroke Foundation of New Zealand, 2008. www.stroke.org.nz

2 Minimum standards

2.1 The overview of a TIA clinical pathway on the next page illustrates the triage criteria for patients with TIA. This is the responsibility of ambulance services, primary care and secondary care clinicians. All need to treat TIA as a ***medical emergency*** and triage patients according to the New Zealand Guideline.

2.2 It is accepted that there will be clinical exceptions to any guideline – for example patient refusal or in special circumstances e.g. in the setting of terminal illness or advanced dementia. Age alone should *not* be used to decide whether a treatment or specialist assessment is appropriate.

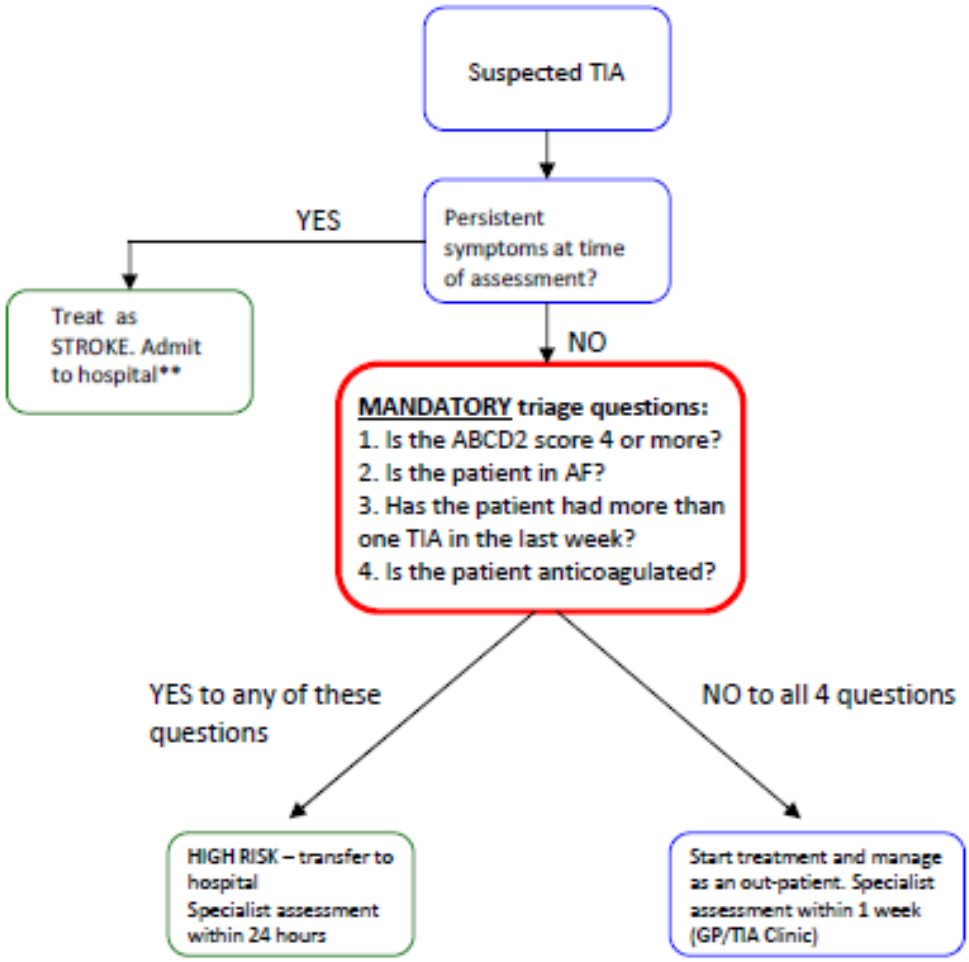
2.3 High risk patients should be sent to their nearest hospital as an emergency for rapid specialist assessment and treatment within 24 hours (it is accepted that in the case of carotid dopplers only, this may extend to 'one working day'). International experience with rapid access TIA clinics has demonstrated that three quarters of patients can be assessed, treated and discharged the same day and that this reduces stroke rates substantially.

2.4 Lower risk patients can be managed in the community but a specialist assessment is recommended and this should occur within 7 days. In most cases this will be via a rapid access TIA clinic. However, if the treating doctor is confident about the diagnosis, can implement recommended treatments, and has access to brain and carotid imaging within seven days, then specialist review of people at lower risk may not be necessary.

2.5 All people with a TIA should be started on treatment within 24 hours, pending further investigations.

2.6 The full assessment, treatment and information that should be given to people with TIA is described in the New Zealand Guideline.

2.7 Triage of people with suspected TIA (New Zealand Guideline):



Notes:

a) If a person presents after one week, they are considered lower risk and can be managed as an out-patient (in the absence of any other reasons for admission).

b) Treatment must be started immediately in all patients.

3 Next steps

3.1 The National TIA Working Group recommends DHBs with either no service or limited services consider use of the MidCentral TIA Electronic Decision Support Tool (supplied by BPAC) for non-specialists who assess and treat people with possible TIA. This tool is:

- specifically designed to aid GPs
- is adaptable to local pathways if they exist, or
- can be implemented as a user-friendly pathway in areas where one is currently lacking.

Further information about this tool can be found by contacting BPAC on 0800 633236 or Dr Anna Ranta at anna.ranta@midcentraldhb.govt.nz .

3.2 We ask that Regional Stroke Networks use the following questions to assess whether they have the appropriate building blocks of a TIA service in place:

TIA Service Checklist

A	Is there a TIA pathway in place?	
B	Is the pathway based on the New Zealand Clinical Guideline?	
C	Are the following groups signed up to the pathway? - Ambulance - ED staff - General Practitioners - Physicians - Radiologists - Vascular Surgeons	
D	Is there a rapid access TIA clinic or equivalent?	
E	Do high risk patients access appropriate imaging within 24 hours? (or in the case of carotid Dopplers only, one working day)?	
F	Do lower risk patients access appropriate imaging within seven days?	
G	Is carotid endarterectomy performed within two weeks of referral?	

3.3 The TIA Working Group debated what national metrics could be recommended, in the absence of adequate information systems, in particular diagnostic coding for outpatient attendances, and the lack of administrative support for clinicians responsible for organised stroke services. Our recommended standards are that national metrics should incorporate data that is already routinely collected; include measures of structure, process and outcomes; and not divert attention away from the most effective aspects of a TIA pathway – ie rapid assessment and treatment (medical and surgical) of all patients.

3.4 Rates of carotid endarterectomy per population (as a high level measure of TIA pathway activity) were debated a great deal, but no consensus to recommend this as a national metric was achieved.

3.5 Individual services are encouraged to regularly audit their own TIA service, using the checklist above and other standards based on the New Zealand Guideline.

Yours faithfully

The National TIA Project Group

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