Western Health and Social Care Trust

Stroke Telemedicine Policy

May 2014

Title	Stroke Telemedicine Policy
Reference Number	PrimCare14/001
Implementation Date	May 2014
Review Date	April 2016
Responsible Officer	Assistant Director, Secondary Care, Directorate of Primary Care and Older People's Services

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1 Introduction

Direct delivery of acute stroke care by specialists cannot always be achieved in every hospital because of geographical issues or staffing shortages. Telemedicine enables a stroke physician to talk to the patient and/or carer, watch a clinical examination and view the imaging to safely evaluate the appropriateness of thrombolysis and other acute treatments, as an alternative to face to face in a specialist stroke centre (RCP 2012).

Delivery of a telemedicine system in acute stroke is primarily to enable assessment of people presenting with acute stroke by a remote specialist in stroke care, to determine eligibility for thrombolysis with alteplase.

Telemedicine in acute stroke may be used to support effective 24 hour stroke specialist advice either at single sites, or across networked sites working in collaboration within or across trusts.

The implementation of a telemedicine system in acute stroke is supportive of a range of standards and quality markers contained in recent policy and guideline publications.

- The National Stroke Strategy (2007) contains quality markers which require patients with a suspected stroke to be transferred to, and assessed at a hyper acute stroke service, available 24 hours.
- NICE Clinical Guideline 68; Acute Stroke and Transient Ischaemic Attack (2008) recommends thrombolysis as a clinically and cost effective treatment for acute stroke.
- RCP National Clinical Guidelines for Stroke (2012) reflects the NICE guidance in acute stroke.

2 Definitions

2.1 Telemedicine

Telemedicine is a real-time audio-visual conferencing system that allows specialists in stroke care to remotely assess patients and to view their CT brain scan images. This enables the remote stroke consultant to advise the local team on the patient's suitability for thrombolysis.

Telemedicine systems consist of a digital network including a two-way video and audio conference facility, plus brain scan image transfer using a high speed- data transmission up to 2 Mb/s.

In acute stroke, the video camera captures real-time clinical signs from the patient, enabling a remote consultant to receive images remotely and hence undertake a remote presence consultation.

2.2 Telemedicine consultant

A remote telemedicine consultant is defined as a consultant with experience of acute stroke, who has demonstrable training, skills and experience in the procedures used to diagnose, treat and oversee patients who will benefit from thrombolysis.

3 Clinical Quality Requirements

3.1 Service Requirements

Various forms of telemedicine (using telephone consultation, video camera linkage with or without remote access to radiology) have been tested in a number of settings over recent years. From the evidence available, it is not yet possible to conclude whether any form of telemedicine for acute decision-making is as good as a standard bedside assessment or whether telephone consultation is better or worse than video-link telemedicine services; however consensus of the working party is that video-linked telemedicine is preferable to telephone. All telemedicine services should have immediate access to Information Technology (IT) support to ensure that the service is available whenever needed (RCP 2012).

The Royal College of Physicians 2012 recommend (*3.4.1)*

a) A telemedicine service in an acute stroke unit should consist of a video link that enables the stroke physician to observe a clinical examination and/or a telephone that enables the stroke physician to discuss the case with a trained assessing clinician and talk to the patient and carer directly.

b) All telemedicine services should have a link that enables the stroke physician to review radiological investigations remotely.

c) An acute stroke unit using a telemedicine service should still include specialist stroke nurses at the admitting hospital.

d) Staff providing care through telemedicine (at both ends of the system) should be specifically trained in the use of the technology and assessment of acute stroke patients, delivery of thrombolysis and other acute interventions in the context of the remote system being used.

e) The quality of decisions made through telemedicine should be regularly audited.

3.2 Agreed Specification for Delivery of Thrombolysis

The agreed specification of telemedicine for the delivery of thrombolysis in acute ischaemic stroke within the Western Health and Social Care Trust is as follows: Appendices 1&2

a) The service will be delivered by stroke consultant or senior staff grade trained in the delivery of thrombolysis and remote telemedicine.
b) Telemedicine will be used for out of hours and public holidays.

c) Telemedicine will be used for the assessment of potential thrombolysis delivery and hyper-acute stroke care post lysis.
d) There will be a co-ordinated rota of identified on-call remote telemedicine consultants available at all specified telemedicine operational hours.
e) Consultants/senior staff grade will have the technical capability to carry out audio-visual teleconferencing and remote access to CT brain scan images during telemedicine operational hours.
f) Following the initial consultation during telemedicine hours, when there are post lysis complications the in house doctor will contact the on call physician for direct patient management, liaising with the stroke consultant responsible for the thrombolysis decision.
g) The monitoring of all lysed patients will be through the SITS register and the WHSCT lysis review meetings. The lysis review meetings will discuss both the clinical and technical service. Patient experiences and opinions to be inbuilt to performance reports.
h) Stroke consultant and stroke co-ordinator will produce activity, performance and patient experience reports, and coordinate regular multidisciplinary outcome meetings and teaching updates.
i) The Remote Stroke Thrombolysis Consultation assessment form will be completed by the remote consultant / senior staff grade. This will be electronic and saved directly onto Patient Centre. A copy must be printed from the Patient Centre and filed in the patients chart. Notes should be made in the patients chart by the assessing doctor onsite at the time of the assessment/treatment, to reflect the decision and care ensuing from the telemedicine assessment.

3.3 Administration Standards

a) The green Regional Thrombolysis Protocol will be completed onsite by the attending doctor.
b) The remote stroke consultant/staff grade will complete the Remote Stroke Thrombolysis Consultation form and save into Patient Centre as detailed in 3.2.9 (Appendix 5).
c) Staff in the stroke unit will print off the copy of the Stroke Thrombolysis Consultation document from Patient Centre and file in the patients' medical notes.
d) Nursing staff will complete the 48 hour Nursing Thrombolysis Pathway for all patients who receive the prescribed bolus/infusion of alteplase.
e) Medical staff to complete a repeat NIHSS 2hrs post time of bolus administration and ensure there are handover arrangements to achieve the 24 hour CT and NIHSS.

3.4 Quality Assuring Equipment

a) Weekly links by the consultant to the telemedicine cart will be made on an agreed day and time (between consultant and department responsible for the telemedicine cart). Any difficulty with connection will be logged via the ICT portal through the Trust intranet, writing Thrombolysis as a title so ICT know to prioritise request.

b) Each consultant is responsible for keeping a record of their log in, if any difficulty encountered and action taken. Records will be stored on the Stroke Sharepoint site.
c) The consultant will ensure the IT department will have access to the laptop on site when the fault is logged, and arrangements are made within the stroke team to ensure a laptop is made available for the stroke consultant on call.
d) Questmark complete annual checks on the telemedicine cart equipment.

3.5 Monitoring Process and Outcomes

a) Review of all cases assessed through the telemedicine system will occur at the Lysis review meetings. Any issues needing raised by the remote consultant/staff grade will be fed back directly to the consultant taking over the care of the patient and the stroke services co-ordinator. Minutes/actions of the lysis review meetings will be circulated to all staff involved in the lysis case.
b) All thrombolysis cases will be scrutinised through the Lysis review meetings. Audit will be achieved by registering every patient on the Safe Implementation of Thrombolysis in Stroke Monitoring Study (SITS-MOST) database and SSNAP Audit.
c) The outcome of cases will be reported back to the WHSCT Trust Steering Group and the Patient Client Safety Steering Group.
d) All clinical incidents will be reported using the Datix system, and discussed at the next lysis review meeting. Appropriate cases identified by consultants will be put forward to the morbidity and mortality meeting.
e) Any major complications or serious adverse incidents should be reported to the Assistant Director for Secondary Care and Medical Director for consideration.
f) The WHSCT complaints procedure will be available to all patients/relatives involved within the stroke service.

4 Clinical Governance Issues

4.1 Patient Consultation via Telemedicine

a) The telemedicine consultation should be in-line with GMC guidance as if the remote telemedicine consultant was at the patient bedside. The patient's privacy and dignity needs to be ensured.
b) Confidentiality of the consultation must be maintained.
c) Obtaining informed consent for the treatment should be performed sympathetically, giving the patients and relatives reasonable time to ask questions.

4.2 Information Governance Issues

Consultants providing telemedicine consultations are bound by their WHSCT contractual arrangements to work within the Data Protection, Confidentiality, ICT Security policies and other relevant policies listed in Appendix 10.

a) The Remote Stroke Thrombolysis Consultation form will be sent via the Patient Centre Portal after the assessment is completed.

b) Any further information regarding the assessment if needed to be communicated via email must be encrypted (Appendix 6)
c) If any part of the telemedicine consultation was to recorded either voice or visual then patient consent must be provided and recorded on the Patient/Client/Carer consent form for the taking of identifiable photographic or video images (Appendix 7)

4.3 Role and Responsibility of the Consultant giving Remote Opinion via Telemedicine

a) The role of the remote telemedicine consultant in relation to stroke thrombolysis is to advise the local team in their trust on the best management of the patient, when their advice is sought.
b) The remote telemedicine consultant is accountable for the advice that is given.
c) Responsibility for the care of the patient remains that of the on-call medical team, or other designated specialist team (e.g. acute stroke unit staff), at the same hospital trust.
d) If the remote telemedicine consultant is working in another hospital or Trust, the patient will at no point be under that consultants care. The patient will be under the care of the acute physician on call until post take ward round when their care should be transferred to an onsite stroke consultant.
e) SWAH - If the remote telemedicine consultant works for the hospital to which the patient has been admitted, the patient will be under the care of the acute physician on call until post take ward rounds, when their care will be transferred to the onsite stroke consultant who completed the thrombolysis.
f) AAH - If the remote telemedicine consultant works for the hospital to which the patient has been admitted, the patient will be under the care of the acute physician on call until post take ward rounds, when their care will be transferred to the onsite stroke consultant on call.
g) In the event of a post lysis reaction/complication the acute physician on call should refer to Trust protocols, however the remote telemedicine consultant will provide on-going support and advice if required.

A remote telemedicine consultant should:

- Have advanced clinical assessment skills in relation to acute stroke management.
- Have an in-depth knowledge and understanding of risks and benefits of thrombolysis therapy in acute ischaemic stroke, including having attended a recognised training course.
- Be responsible for the delivery of care based on current evidence, best practice and, where possible, validated research.
- Be responsible and to work to standards, guidelines, protocols and policies agreed within the Western Health and Social Care Trust.
- Be trained in stroke thrombolysis, and receive training updates.
- Be regularly involved in the provision of both day-time and out-of hours thrombolysis for acute stroke.
- Be trained in the use of the telemedicine equipment.
- Be able to perform an NIHSS stroke assessment.

- Be trained in the interpretation of CT head scans.
- Attend regular multidisciplinary thrombolysis review meetings.

A remote telemedicine consultant should possess the core skills to undertake the following tasks:

- Reviewing clinical information provided on the patient.
- Reviewing time of onset/time last seen well.
- Assessing and conversing with patient via video-link.
- Reviewing physiological parameters.
- Reviewing inclusion and exclusion criteria.
- Reviewing medication.
- Reviewing CT imaging.
- Explaining to patient and/or family the risks and benefits of thrombolysis if appropriate.
- Assisting the local team in obtaining informed consent.
- Advising the local team as to whether thrombolysis is appropriate or not.
- Providing guidance on any other issue relevant to care of the person with acute stroke.

4.4 Roles and Responsibilities of Clinicians seeking Remote Opinion

The clinician seeking advice from the remote telemedicine consultant has the responsibility of having demonstrable appropriate training and skills, and a requirement to adhere to guidelines and protocols, they should:

- Have completed training in NIHSS scoring.
- Have completed in house thrombolysis training course
- Follow the protocol for contacting the remote stroke specialist.
- Ensure that the appropriate diagnostic scan is acquired speedily, usually within 30 minutes of the patient's arrival.
- Assess the patient using the Northern Ireland Thrombolysis for acute ischaemic stroke – Rapid Assessment Protocol.
- Provide the remote telemedicine consultant with a detailed assessment of the patient in order to enable both clinicians to complete the approved checklist.
- Enable a clearly auditable process for making the decision to thrombolyse or not.
- Ensure that the thrombolysed patient is transferred to a hyper acute bed within the stroke unit.
- Ensure a thorough handover of the details of patient treatment and condition takes place.

4.5 Responsibilities of Organisations providing Care for People with Acute Stroke

Each organisation must have organised hyper-acute stroke care on a unit designated for hyper-acute stroke. Each unit must meet the seven acute criteria for units with beds providing care in the first 72 hours:

- Continuous physiological monitoring (ECG, oximetry, blood pressure) for 24 hours.
- Immediate access to scanning for urgent stroke patients.
- Direct admission from A&E/front door.
- Daily post take ward round to review all acute stroke patients admitted
- Acute stroke protocols/guidelines.
- Nurses trained in swallow screening.
- Nurses trained in stroke assessment and management.
- The unit must be staffed to provide specialist 1:2 nursing for the first 24 hours and subsequently for recommended stroke unit intensity.
- Staff must be trained in the provision of thrombolysis for acute ischaemic stroke.
- Staff must be trained in the management of complications of thrombolysis.
- Protocols for stroke thrombolysis and the management of complications must be in place.
- The unit must be able to provide care to the standards set out in the RCP Clinical Guidelines 2012, NICE guidelines for Acute Stroke and TIA 2008, and the RCP National Sentinel Audit standards 2012.

4.6 Workforce Issues

- Trusts will be required to provide sufficient qualified and appropriately trained staff to support the use of telemedicine in acute stroke.
- Consultants working in another Trust providing telemedicine assessments within the WHSCT will have an honorary contract completed and signed.
- The WHSCT is responsible for approving medical and nursing staff members involved with using the telemedicine system as being competent in the use of the equipment, assessment process and the contingency measures if equipment failure should occur.
- An appropriate competency assessment process for all telemedicine consultants will be signed off by the IT department staff (Appendix 9). The onsite medical and nursing staff will be signed off by identified trainers within stroke services (Appendix 8).

4.7 Technical Failure – Appendices 3&4

- Technical failure is the key risk in the usage of telemedicine and remote consultation in the emergency care of people with acute stroke.
- The telemedicine consultant should be provided with a laptop and have access to adequate broadband capability, 2mb to support PACS images.
- It is recommended that laptops should be plugged into the main phone line for connection (Wi-Fi speeds are a lot slower than direct connection).

4.7.1 CT Down Time

- Within Altnagelvin Hospital there is a 2nd CT scanner available to cover downtime for essential maintenance.
- Within the South West Acute Hospital there is only one CT scanner. When essential maintenance is planned or breakdown occurs, bypass policy will be followed.
- The A&E consultant will inform the Northern Ireland Ambulance Service and FAST positive patients will be diverted to the nearest lysis centre.

4.7.2 Telecart Failure

- It is the responsibility of the consultant on call to have checked the connection with the telemedicine cart during normal working hours (9am -5pm) in advance of being on-call (section 3.5.1).
- If there is a failure in connection out of hours, contact switchboard who will contact IT on-call.
- Consultation by telephone can proceed only if both an attendant physician on site has experience in thrombolysis in acute stroke and an opinion on the scan from a local radiology consultant can be obtained (section 3.1)

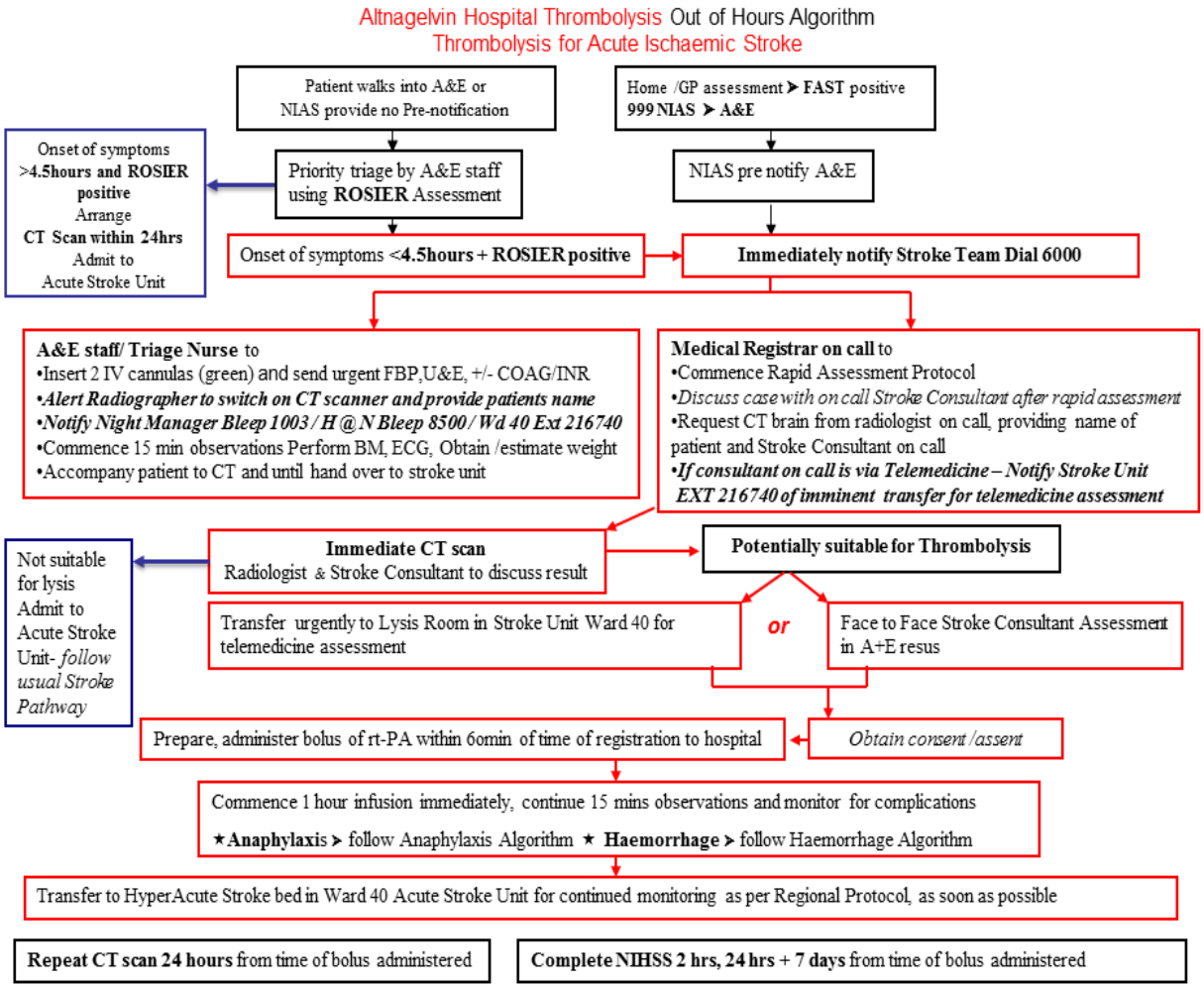
5 Equality Statement

This document has been screened for Equality and Human Rights issues. No issues have been identified and no further action is required. A full Equality Impact Assessment is not recommended/required

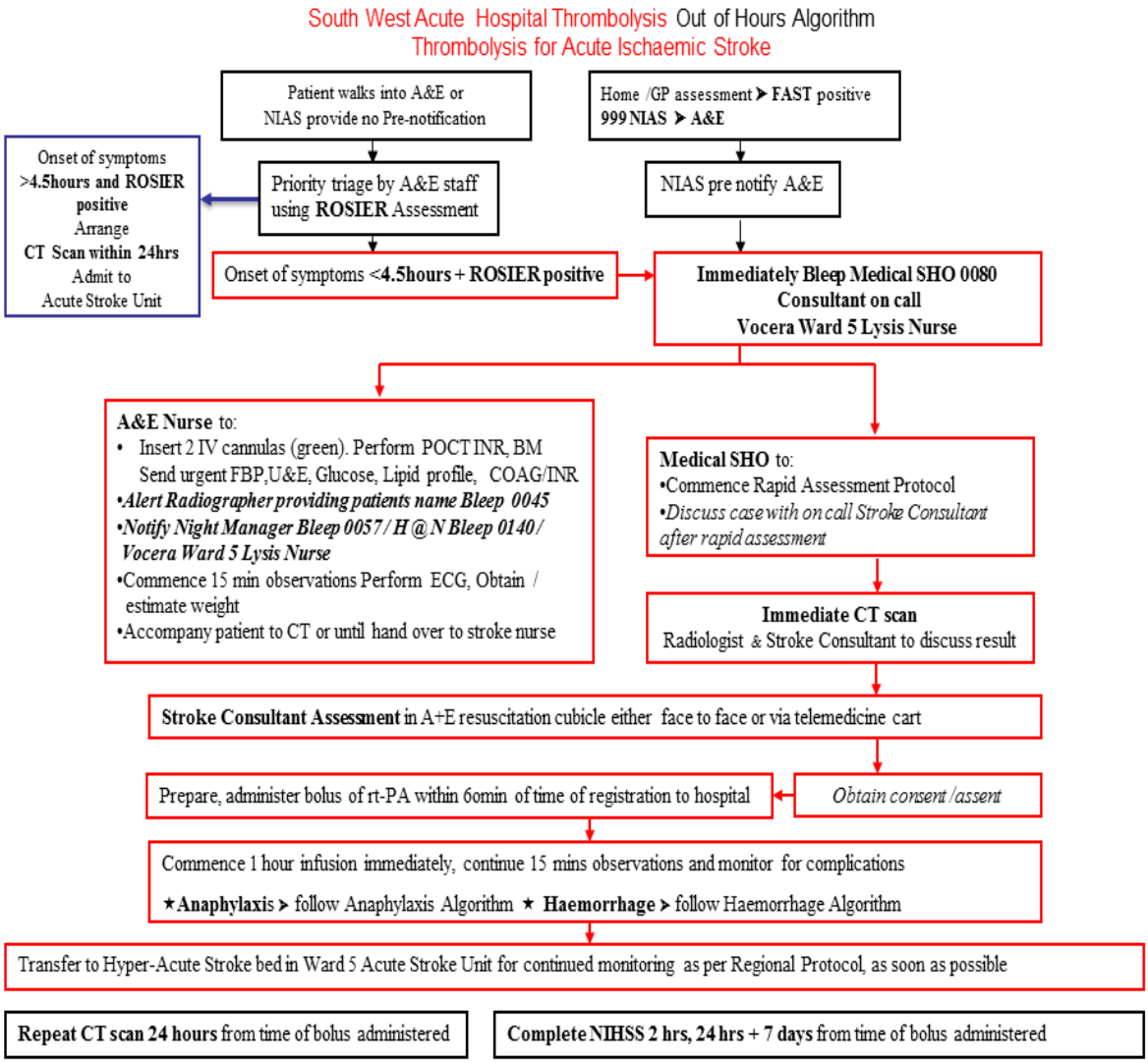
6 Glossary of Terms

BMA	British Medical Association
CT	Computerised Tomography
FAST	Face Arm Speech Time
GMC	General Medical Council
NICE	National Institute of health and Clinical Excellence
NIHSS	National Institute of Health Stroke Scale
PACS	Picture Archiving and Communication System
SITS	Safe Implementation of Thrombolysis in Stroke
SITS-MOST	Safe Implementation of Thrombolysis in Stroke – Monitoring Study
ROSIER	Recognition Of Stroke In an Emergency Room
SSNAP	Sentinel Stroke National Audit Programme
SWAH	South West Acute Hospital
AAH	Altnagelvin Hospital

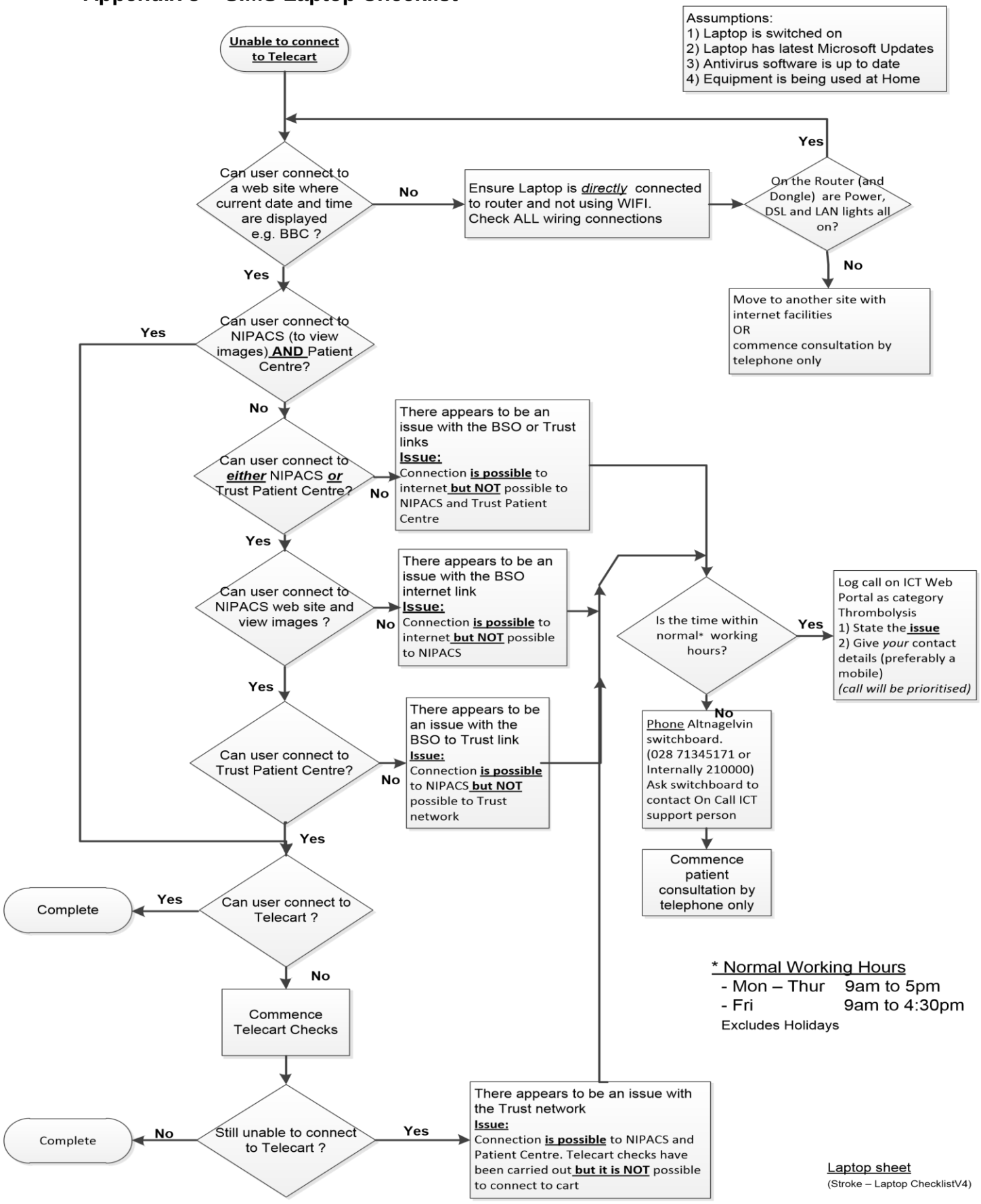
Appendix 1 Pathway for Out Of Hours Stroke Telemedicine Altnagelvin



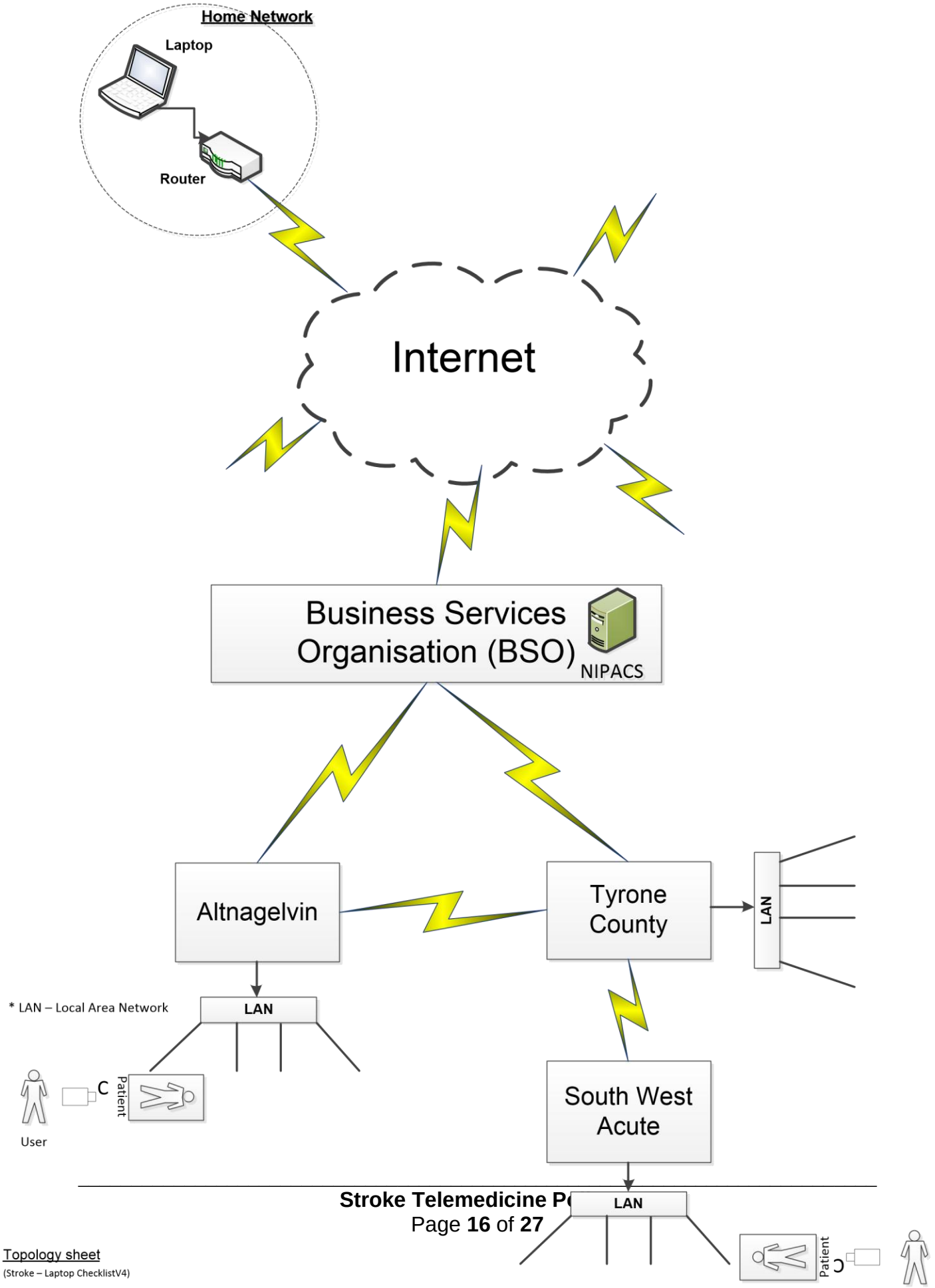
Appendix 2 Pathway for Out Of Hours Stroke Telemedicine SWAH



Appendix 3 – SIMS Laptop Checklist



Western Trust - SIMS
Network Topology



Appendix 4 – SIMS Telecart Checklist

Telecart

Check the following Telecart Equipment Connections

Rear of Camera

Rear of Monitor - RHS

Rear of Monitor - LHS

Network Connection

Has Telecart been moved to NEW Location or NEW IT connection?

Yes → Telecart will only work at specific location or network point ! Move Telecart or connect to identified network connection!

No

Is the Cart powered on (for at least 10mins) ?

No → Is this your first attempt?

Yes → Power on telecart; allow 5-10 minutes for unit to *fully* power up

No → Is the time within normal* working hours?

Yes → Log call on ICT Web Portal as category Thrombolysis
1) State the **issue**
2) Give *your* contact details (preferably a mobile)
(call will be prioritised)
→ Commence patient consultation by telephone only

No → Phone Altnagelvin switchboard. (028 71345171 or Internally 210000) Switchboard will contact On Call ICT support person
→ Commence patient consultation by telephone only

Yes → Ensure Microphone/ Camera lights are Green

→ Ensure Monitor is Switched on

→ - DO NOT Touch Remote unless instructed
- DO NOT Touch any button on screen unless instructed

→ Consultant should now be able to link in

Power light

Power button

Remote Control

* Normal Working Hours
- Mon – Thur 9am to 5pm
- Fri 9am to 4:30pm

Excludes Holidays

Important Notes:
1) It may take 5 to 10mins for the video unit to fully power up after being switched on
2) DO NOT move the Telecart to another room OR network point WITHOUT agreement from the Group (ICT, Stroke co-ordinator)

Telecart sheet
(Stroke – Laptop ChecklistV4)

Appendix 5

Remote Stroke Thrombolysis Consultation

Delete as appropriate - Video-link or Telephone assessment

Remote Consultant Stroke Physician_____

Assessing Doctor and grade in Hospital_____

Date /Time call received_____Time assessment began_____

Patient name DOB Hospital Number	Date/ Time of stroke onset Time of call

Is the time of onset clearly known? Yes/No

Can the patient receive thrombolysis within 4 ½ hours? Yes/No

Has the patient had a seizure? Yes/No

Is there a history of sudden onset thunderclap headache? Yes/No

Are there significant migrainous features? Yes/No

BP

BM

GCS

POCT INR On warfarin Yes/No If yes- INR PLT

What is the NIHSS score?

Brief summary of history and clinical features;

CT date/ time CT scan findings;

Contraindications list completed Yes/No

Any concerns?

Discussion with patient or relative;

Consent obtained Yes/No

Decision to lyse Yes/No

Agreed Alteplase dose

Time of bolus Time of infusion

Appendix 6

Encrypting Confidential Files for Email

Background and Context

This section will show you how to use jZip software to both compress and encrypt confidential document(s).

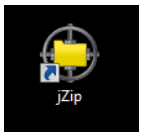
What is jZip

jZip is free file compression software that also allows the user to apply a high level of encryption. It has a higher level of encryption than the Microsoft Office Suite (Word, Excel, PowerPoint etc)

The following instructions will show you how to create a compressed file, add files to be compressed, set an encryption level and enter a password.

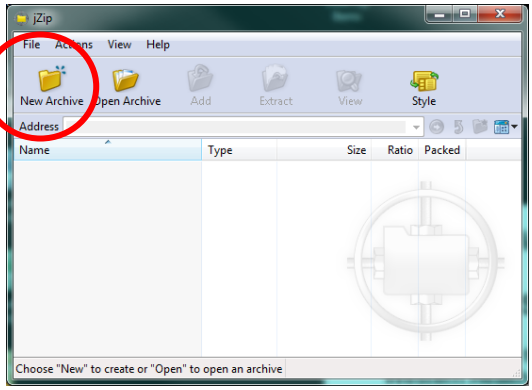
Creating a Compressed File

This is the container for the confidential files.



1. Double click on the jZip Icon on the Desktop to start the Program
   Or Click on Start > All Programs > jZip > jZip

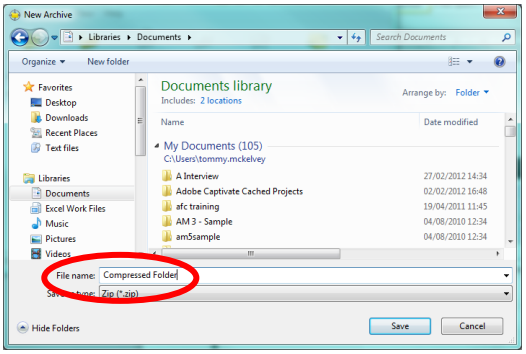
2. Click on the New Archive button



Encrypting Confidential Files for Email (continued)

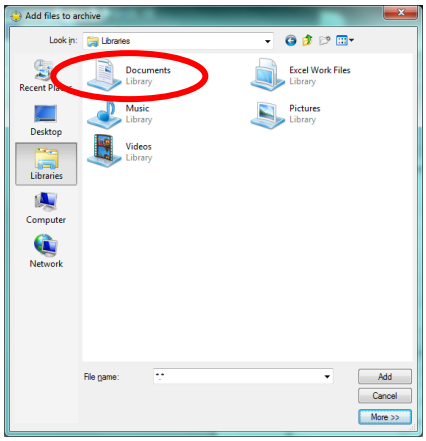
3. Select a Name and a location for the compressed file.

4. Click **Save**



This will normally be in your Documents folder

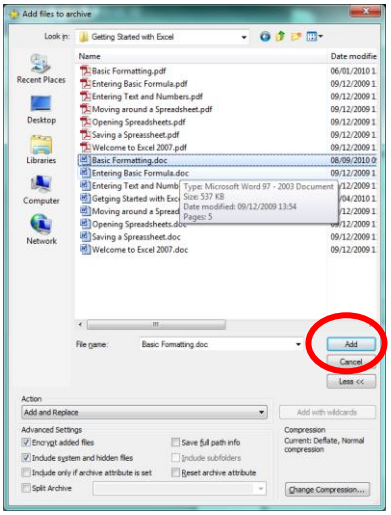
5. Add the file(s) to be compressed



Navigate to the file(s). These will also be in your Documents folder.

This is similar to opening a file in Word

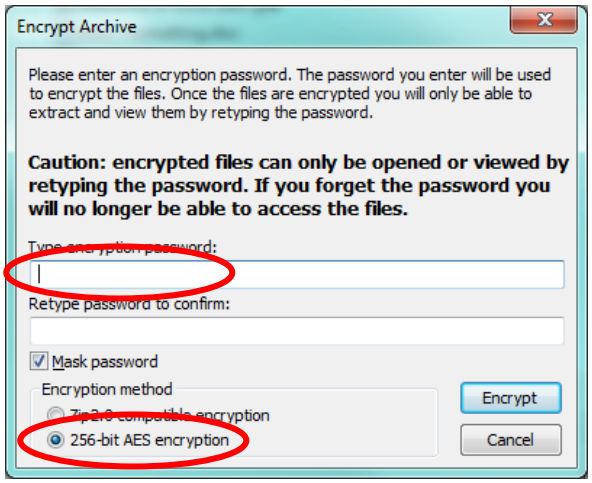
6. Click on the **More** button and Check the option to **Encrypt**.



7. Select the File(s) and Click the **Add** button

Encrypting Confidential Files for Email (continued)

8. You will be prompted to enter a password and set the encryption level.

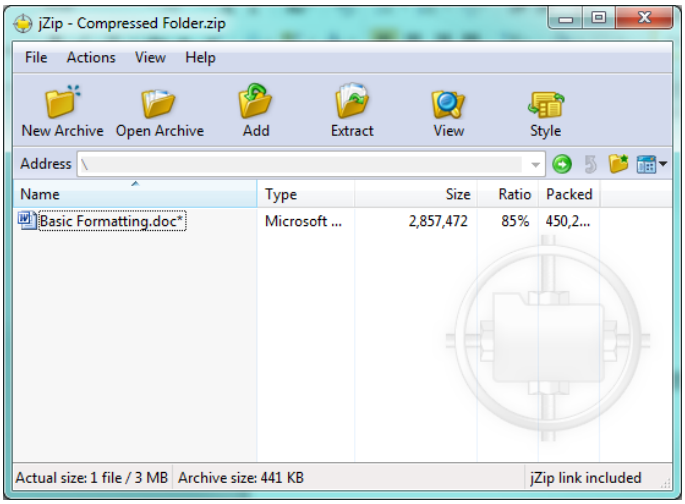


Enter a suitable password and set the encryption to 256 bit AES encryption

9. Click on **Encrypt**

The file(s) will now be added to the compressed (zip) file as shown

This completed the process and this window can be closed unless there are more files to be added.



The compressed file (.zip) that you have created can now be attached to an email and sent to the appropriate person.

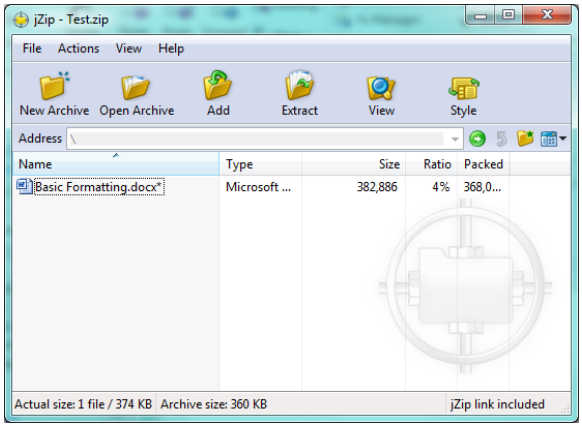
Encrypting Confidential Files for Email (continued)

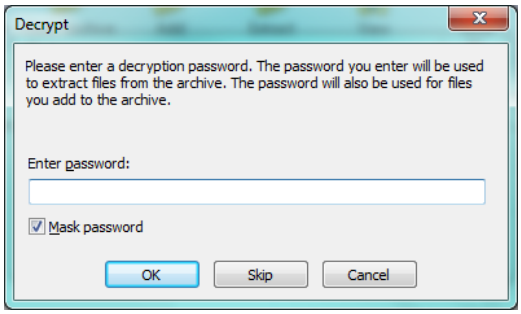
How to Open a Compressed and Encrypted File

1. Simply Double click on the attached file in the normal way to open it.

2. Double Click on the File to be opened.

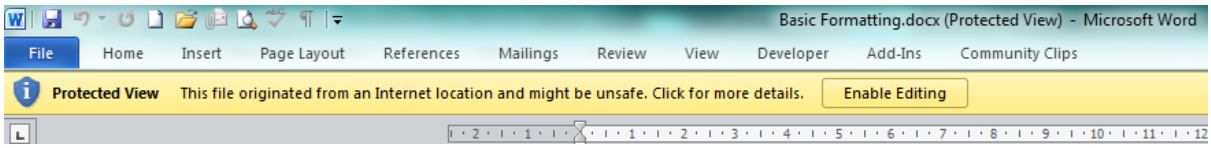
3. You will be prompted to Enter the password





4. The Document will now open in Protected view.

5. Click on Enable Editing to allow you to make changes or print the document.



NOTE **If the screens above do not appear, you will need to contact the ICT Helpdesk (71865124 or 215555) and Log a request to have jZip installed on your computer.**

Appendix 7

PATIENT/CLIENT/CARER CONSENT FORM FOR THE TAKING OF IDENTIFIABLE PHOTOGRAPHIC OR VIDEO IMAGES

Part 1. (Enter details OR affix label)

Name of Patient: _____

Address:

_____

_____

Date of Birth:

_____

Ward:_____**Consultant:**_____

Part 2. To be completed by the person requesting the photographic or filmed images:

I confirm that I have requested the consent of the above patient, or the person with parental
responsibility for this patient (the carer), for *identifiable* photographic or filmed images to be
taken for one or both of the following purposes – please tick and initial:

For Trust / hospital publications including the Trust website, Annual Report, information booklets, posters, banners, video presentations and other public documents ☐

For other publications including newspapers, magazines, journals, or for broadcast on television, or as part of a film, or for education or research. ☐

☐ I have provided the patient/carer with a full explanation of the purposes for which these images will be used.

☐ I have informed the patient/carer of his/her right to refuse consent.

☐ I have advised that the patient will be identifiable from the images taken. I have also explained that it may *not* be possible to control future use of these images once they are in the public domain.

☐ I have explained that, in the case of images taken for Trust/hospital purposes, the Trust will accept responsibility for the safe storage of the images and any negatives and for the proper disposal of same.

SIGNED:_____DATE_____

FULL NAME (BLOCK CAPS):

Part 3. To be completed by the patient named overleaf or his/her carer:

I have been asked for my consent to have photographic or filmed image(s) taken. I understand
that anyone looking at those images will be able to identify me/the patient.

I confirm that the following has been explained clearly to me:

- the purpose(s) for which the image(s) will be used.
- that these images will be published
- that I may refuse consent to these images being taken
- that I may withdraw my consent at any time although I understand that in some instances, where the images have already been used, it may not be possible to control their further use.

I consent to photographic/filmed image(s) being taken as explained to me.

SIGNED:_____DATE:_____
(Patient/Carer)

Full name (block capitals) if not patient
_____
_____

Appendix 8

Nurse/ On-site medical staff - Telemedicine Competency checklist

Name:

I confirm that the above person has completed the training required and obtained the competencies for participation in telemedicine stroke thrombolysis pathway.

	Telemedicine Competency Nurse	
	Telemedicine Competency Check list	Achieved
1	Knows where the equipment is stored and plugged in to charge	
2	Can move cart to required position and plug into both sockets	
3	Can turn on cart	
4	Knows how to recognise if the volume has switched off	
5	Knows how to access on call consultant for lysis rota	
6	Can explain the process to the patient or carer	
7	Can shut down software and cart and return to storage	
8	Knows how to seek help and advice on technical system	
9	Knows how to report faults	
10	Is aware of care and cleaning obligations	
11	Understands the need for regular checks on the equipment	
12	Understands the immediate course of action if system is not working	
13	Provide date of when Thrombolysis training completed	
14	Provide date of Acute Nurse Management/Post lysis complications training	
15	Provide date for completion of ILS/Anaphylaxis training completed	

Trainer Name_____

Trainer Signature_____

Date_____

Appendix 9

Telemedicine Consultant Competency checklist

Name:

I confirm that the above person has completed the training required and obtained the competencies for participation in the telemedicine stroke thrombolysis pathway.

	Telemedicine Competency Consultant	
	Telemedicine Competency Check list	Achieved
1	Can turn on laptop and check status of antivirus	
2	Knows how to connect laptop to Home network	
3	Knows the difference between WIFI and direct connection to router	
4	Knows how to use Crypto card to access Trust Systems	
5	Knows how to use the Web browser, Internet Explorer	
6	Knows how to connect to an internet site (e.g. BBC)	
7	Can connect to NIPACS and view images	
8	Can connect to Patient Centre	
9	Knows how to use Cisco Jabber Video	
10	Can connect to Telemedicine cart in Altnagelvin / SWAH	
11	Knows how to advise Nurse/Medic on issues such as; - No sound - Out of focus - Resetting Telecart equipment	
12	Knows how to seek help and advice on technical system	
13	Knows how to report ICT faults via ICT Web Portal during normal hours	
14	Knows how to report ICT faults to Altnagelvin Switchboard – out of hours	
15	Understands the immediate course of action if system is not working	
16	Understands the need to check Trust Connections on a weekly basis e.g. NIPACS and Patient Centre	

Trainer Name_____

Trainer Signature_____

Date_____

Appendix 10

Policies

- Data Protection and Confidentiality Policy 2013
- Records Management Policy 2013
- Incident Reporting Policy and Procedures 2012
- Server, Desktop and Portable Security Policy 2011

Guidelines

- HSSPS Good Management, Good Records (G99) 2006
- Royal College of Physicians' Intercollegiate Clinical Guidelines for Stroke 4th edition 2012
- NICE (CG) Stroke Diagnosis and initial management of acute stroke and TIA 2008
- NICE (CG) Alteplase for the treatment of acute stroke 2007

Standards

- Royal College of Physicians' National Sentinel Audit standards 2012