MODULE 13: Cardiology

CARDIOVASCULAR DISEASE and its contributory factors is the most significant public health problem that we have faced in recent times.

The WIN Continuing Education section is continuing to focus on this important clinical area throughout 2007, given that it impacts on all areas of the Irish health service.

Diabetes mellitus is one of the primary risk factors for the development of coronary heart disease, and the focus on diabetes management will also continue this year. Guidelines for the management of both CVD and diabetes include: risk factor management, lifestyle modification, pharmacological intervention and patient education.

This month the Cardiology Module focuses on the role of a special stroke unit in rehabilitation and secondary prevention of stroke. It also explores the core concepts of the role of the clinical nurse specialist in stroke care.

PART 3

Stroke units

Role in rehabilitation

by Niamh Dixon

STROKE is the third leading cause of death in the world and the leading cause of disability in developed countries. It is a disease which has great consequences for patients and their families.

In a recent randomised control trial which looked at national variations between western countries in mortality and functional outcome after stroke, Ireland was shown to have the highest death and dependency rate after six months post stroke than any other country in the world. Stroke is the third leading cause of death in Ireland, with an estimated 10,000 strokes a year – 2,500 of which are in young to middle-aged people.

There are about 30,000 people in Ireland with some form of disability following stroke, including:
- Hemiparesis (48%)
- Needing help with activities of daily living (24%-53%)
- Reduced mobility (22%)
- Clinical depression (32%)
- Cognitive impairment (33%).

Stroke accounts for 8%-10% of admissions through the emergency departments of Irish hospitals. Considering that Ireland is one of the richest countries in the world, both Irish hospitals and community services are under-resourced and ill-focused for the needs of Irish people with stroke.

Role of the CNS in stroke rehabilitation

The role of the clinical nurse specialist in stroke care incorporates the five core concepts of: clinical focus, staff education, patient advocacy, patient education, and research and auditing.

Clinical focus

This is divided into indirect and direct care. Indirect care includes:
- Activities that influence others in their provision of direct care
- Working with staff nurses, care attendants and everyone who is providing care for the patients
- Advising and ensuring that the correct care is being carried out for each patient
- Assisting and observing the nurses in carrying out activities of daily living with patients
- Promoting staff development in stroke rehabilitation.

Direct care includes:
- Assessing, planning and executing the delivery and evaluation of care to patients and their families
- Assessing and evaluating care plans, dependency scales, continence management, etc.
- Talking to patients and their families.

Staff education

Stroke survivors sometimes feel shocked and have altered emotions producing feelings of intense frustration, a sense of loss of role, together with a general experience of loss and grieving, social isolation and depression. All of this presents a challenge for those who plan the care of or care for these people.

Education and training of staff consists of structured and unstructured educational opportunities to facilitate staff development, including: talks; study days/conferences; continuous weekly education sessions; and a monthly stroke journal club for nursing staff, multidisciplinary staff and the medical team.

Patient advocacy

This role entails being a ‘voice’ for the patient, advising and communicating with them and letting them come to terms with their stroke. It involves counselling, support, listening and negotiating. The CNS is charged with encouraging their patient to see that their life is not over and to identify their attitude towards rehabilitation. It is necessary to assessing the readiness of the patient to learn and to identify barriers that will interfere with their learning ability. Realistic, short-term goals need to be set that are understood and agreed by patient.

This role also involves identifying the family’s attitude towards rehabilitation. The CNS must assess the ability of the carer to become involved in the rehabilitation programme and help them to come to terms with the stroke. It involves developing learning techniques that enable the family to help with discharge plans.

Patient education

Patient education involves meeting with patients every day and supplying information booklets on stroke as needed. A ‘stroke club’ is held one afternoon a week, at which patients can come and discuss a particular topic or speak about their stroke and how it has affected them. It is important that patients and
their family are educated on secondary stroke prevention. Families need to be helped to develop goals in the rehab programme. They are encouraged to come to sessions and to participate. If families have confidence in their own ability and knowledge of the recovery process, they gain confidence to take their ‘loved ones’ home.

Research and auditing

This role involves: auditing nursing documentation and care plans; questionnaires for patients and staff; and improvements implemented; database on how many stroke admissions, discharges, types of stroke, etc. and research and publication.

Consultant’s role

The consultant’s role includes the pre-admission assessment of all patients from the acute stroke unit in the Mater Hospital. Stroke rehabilitation units

Stroke rehabilitation units can be established in geriatric medicine, neurology or rehabilitation medicine. Research shows that organised multidisciplinary care in stroke units reduces the risk of disability, deaths and the need for long-term institutionalised care. Focus on prevention and treatment strategies, specialised stroke services and proper management of care are proven to reduce the burden of death and disability. This specialised care is best delivered in acute stroke units, designated stroke rehabilitation units, rehabilitation outpatient and stroke prevention clinics. These services should be run by specialised, trained staff, including nurses and other healthcare professionals.

Hibernian Stroke Rehabilitation Unit, St Mary’s Hospital

In July 2006 the six-bed Hibernian Stroke Rehabilitation Unit opened in St Mary’s Hospital, Phoenix Park, Dublin. This unit caters for all age groups. The philosophy of the unit includes the belief that rehabilitation is a proactive, person-centred and goal-orientated process that begins the first day after stroke. The aim is to improve or prevent deterioration of function, in order to bring about the highest possible level of patient independence – physically, psychologically, socially and financially.

The Hibernian Stroke Unit is unique in that the medical director of the hospital is also the lead consultant geriatrician, Dr Dermot Power, and the associate director is Dr Peter Kelly, consultant neurologist and director of stroke services at the Mater Hospital.

A CNS in stroke care is the clinical co-ordinator of the Hibernian Unit. This role provides a link between the Acute Stroke Unit at the Mater and the Hibernian Unit. The CNS acts as the spokesperson for all disciplines working in the unit, overseeing that the unit runs smoothly and sorting out any problems that may occur.

The neurology registrar at the Mater Hospital provides the CNS in St Mary’s with a list of possible patients who might benefit from treatment at the Hibernian Unit. The CNS and the senior medical social worker then complete a comprehensive pre-admission assessment on potential candidates in the acute stroke unit/stroke rehabilitation unit in the Mater Hospital.

The key component of a successful stroke unit is the presence of a co-ordinated multidisciplinary team consisting of medical, nursing, occupational therapist, physiotherapist, social worker, speech and language therapist, dietician and psychologist.

Plans for the future

A detailed proposal is being drawn up to extend the Hibernian Stroke Rehabilitation Unit to accommodate a total of 18 beds, six of which for use as a step-down facility.

There are also plans to develop a nurse-led post stroke assessment clinic in St Mary’s. The aim of this would be to implement and expand the Heartwatch programme to include secondary prevention of stroke in primary care. At present, the Heartwatch programme does not cover stroke. When approval from the Heartwatch committee is obtained to use its programme, it is proposed to use a similar algorithm for stroke. We propose that this project is run on a pilot basis for the first year.

It is envisaged that patients discharged from the Hibernian Stroke Unit would attend a post stroke assessment clinic in St Mary’s for a monthly review for six months, followed by one review at the stroke prevention clinic in the Mater before being discharged back to their GP.

Patients are always advised to attend their GP within one month of discharge from the Hibernian Stroke Unit. A discharge letter will be sent by the CNS in stroke rehabilitation to the GP informing them of the dates that their patient will be attending the post stroke assessment clinic. An advisory contact number will be distributed to all general practices for any GP queries, and patients will be brought back for review if necessary.

The dietitian manager and the senior medical social worker who work in the Hibernian Stroke Rehabilitation Unit plan to review patients at each post discharge once monthly visit.

It is envisaged that setting up of this post-stroke assessment clinic will form a link between both stroke prevention clinics (Mater and St Mary’s Hospital) and GP practices.

References on request from nursing@medmedia.ie (Quote: Dixon, N. WIN 2007; 15(3): 45-46)