part 2 of 3

Stroke Nursing Study Day

presented by
The Stroke Service, St. James’s Hospital
and
with thanks to
The Emergency Department, St. James’s Hospital
Advanced Stroke Nursing, St. Vincent’s Hospital
Speech and Language Department, St. James’s Hospital
Social Work Department, St. James's Hospital

November 2009

The Emergency Nurses
Role in Thrombolysis

Siobhan Herdman
Emergency Department
St James’s Hospital Dublin
Triage

- Quick, rapid assessment and priority of need to be seen
- Brief, concise history taken by triage nurse
- No delay to perform baseline observations or other investigations
- Immediate transfer to resuscitation area for further assessment
### Triage Group: Target Times

- **First**: 0 min
- **Second**: 10 min
- **Third**: 60 min
- **Fourth**: 120 min
- **Fifth**: 240 min

### Flow Chart

<table>
<thead>
<tr>
<th>No.</th>
<th>Flow Chart</th>
<th>No.</th>
<th>Flow Chart</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Abdominal Pain in Adults</td>
<td>26</td>
<td>Headache</td>
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<tr>
<td>2</td>
<td>Abdominal Pain in Children</td>
<td>27</td>
<td>Head injury</td>
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<tr>
<td>3</td>
<td>Abcesses and local infections</td>
<td>28</td>
<td>Irritable child</td>
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<td>Allergy</td>
<td>29</td>
<td>Limb problems</td>
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<td>Apparently drunk</td>
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<td>Limping child</td>
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<td>6</td>
<td>Assault</td>
<td>31</td>
<td>Major trauma</td>
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<td>7</td>
<td>Aesthesia</td>
<td>32</td>
<td>Mental illness</td>
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<td>8</td>
<td>Back pain</td>
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<td>Neck pain</td>
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<tr>
<td>9</td>
<td>Behaving strangely</td>
<td>34</td>
<td>Overdose and poisoning</td>
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<tr>
<td>10</td>
<td>Bites and stings</td>
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<td>Palpitations</td>
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<td>11</td>
<td>Burns and scalds</td>
<td>36</td>
<td>Pregnancy</td>
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<td>12</td>
<td>Chest pain</td>
<td>37</td>
<td>PV Bleed</td>
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<tr>
<td>13</td>
<td>Collapsed adult</td>
<td>38</td>
<td>Rashes</td>
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<td>14</td>
<td>Crying baby</td>
<td>39</td>
<td>Self Harm</td>
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<tr>
<td>15</td>
<td>Dental problems</td>
<td>40</td>
<td>Sexually acquired infection</td>
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<tr>
<td>16</td>
<td>Diabetes</td>
<td>41</td>
<td>Shortness of breath in adults</td>
</tr>
<tr>
<td>17</td>
<td>Diarrhoea and vomiting</td>
<td>42</td>
<td>Shortness of breath in children</td>
</tr>
<tr>
<td>18</td>
<td>Ear problems</td>
<td>43</td>
<td>Sore throat</td>
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<tr>
<td>19</td>
<td>Exposure to chemicals</td>
<td>44</td>
<td>Testicular pain</td>
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<tr>
<td>20</td>
<td>Eye problems</td>
<td>45</td>
<td>Torso injury</td>
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<tr>
<td>21</td>
<td>Facial problems</td>
<td>46</td>
<td>Unwell adult</td>
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<tr>
<td>22</td>
<td>Falls</td>
<td>47</td>
<td>Unwell child</td>
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<tr>
<td>23</td>
<td>Fiz</td>
<td>48</td>
<td>Urinary problems</td>
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<tr>
<td>24</td>
<td>Foreign body</td>
<td>49</td>
<td>Worried parent</td>
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<tr>
<td>25</td>
<td>GI bleeding</td>
<td>50</td>
<td>Wounds</td>
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</table>
Acute Neurological Deficit

Any loss of neurological function that has come on within the previous 24hrs. This might include altered or lost sensation or weakness of the limbs (either transiently or permanently).

Initial Assessment

- ABC’s - prepare for intubation if needed
- Head to Toe Examination
- Cardiac monitoring
- Baseline vital signs & neurological obs & BSL.
  Sao2 on air, 10 litres O2 routine for severe stroke to keep Sao2 above 95%
- GCS every 15 mins, particularly assess for any deterioration in motor component on affected side on re-evaluation and report any change from initial assessment. Report drop in GCS of 1 to Stroke team.
- History – collateral hx obtained from family if necessary
Initial Assessment

- IVC/Bloods  FBC & COAG
  U&E & Glucose
- ECG
- CXR only if otherwise indicated.
- Pt highlighted to senior medical officer
- CT dept alerted re Brain Imaging

Indications for Urgent CT scan of Head in Stroke

On anticoagulant.
Known bleeding tendency.
Depressed level of consciousness.
Unexplained progressive or fluctuating symptoms.
Papilloedema, neck stiffness or fever.
Severe headache at onset.
Indications for thrombolysis or early anticoagulation.
What is the rationale for the use of thrombolysis in acute ischaemic stroke?

The infarction may take several hours to complete, creating a “time window” during which it may be possible to restore blood supply to the affected area of the brain and interrupt or reverse the process. This minimizing subsequent neurological disability, and secondary complications. Following infarction, cells in the infarct core are intensely ischaemic and begin to die due to hypoxia.
As the cell dies neuroactive substances are released that damage the surrounding area. This zone of secondary damage represents potentially salvageable tissue (penumbra).

What is the rationale for the use of thrombolysis in acute ischaemic stroke?

Theoretically, rapid lysis of a blood clot with a thrombolytic agent can dissolve the thrombus within the blocked vessel and restore blood flow to any ischaemic cerebral tissue that has not been irreversibly damaged. This prevents further evolution of the stroke and deterioration of brain tissue.

Urgent medical care is crucial as 'time is brain'.
Documentation

**Inclusion/Exclusion**

Wide range of questions to which the answer must be **no** for Inclusion

- Seizure at onset
- Pregnancy or childbirth within 4 wks
- Colitis/oesophageal varices or active PUD
Modified Rankin Scale

DESCRIPTION

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No symptoms at all</td>
</tr>
<tr>
<td>1</td>
<td>No significant disability despite symptoms; able to carry out all usual duties and activities</td>
</tr>
<tr>
<td>2</td>
<td>Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance</td>
</tr>
<tr>
<td>3</td>
<td>Moderate disability; requiring some help, but able to walk without assistance</td>
</tr>
<tr>
<td>4</td>
<td>Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance</td>
</tr>
<tr>
<td>5</td>
<td>Severe disability: bedridden, incontinent and requiring constant nursing care and attention</td>
</tr>
<tr>
<td>6</td>
<td>Dead</td>
</tr>
</tbody>
</table>

Adverse reactions to rt-PA

- Thrombotic embolisation has occurred rarely.
- Nausea, vomiting, hypotension, fever may occur rarely
- Isolated cases of CNS events such as convulsions.
- Rare reports of anaphylactic reactions (rash, urticaria, bronchospasm, hypotension, angioedema or shock).
Acute Nursing Management of Thrombolysis

- Early identification of the Acute Stroke pt by the triage nurse
- Confirmation of symptoms onset less than 120 minutes from presentation
- Obtain stroke box and follow stroke protocol
- Highlight need for HDU bed as soon as possible.

Documentation

- Time of onset of symptoms
- Assess for inclusion/exclusion criteria
- Past medical/surgical history
- Medications/Allergies
- If patient on warfarin or other anticoagulant note time of last dose and ensure INR & coag sent.
- If patient on warfarin this is an indication for urgent ct to assess for haemorrhage
PRIOR TO STARTING rt-PA

- Ensure CT brain reviewed by senior radiologist and consultant stroke physician on call, if unavailable r/v by consultant neurologist - exclude haemorrhage
- Confirm availability of consent
- Patient weight estimated
- Tpa prepared as per thrombolysis guidelines
- Tpa to be administered by consultant stroke physician or consultant neurologist only

Prior to starting rt-PA

- Dose does not exceed maximum dose of 90mgs (see weight /dose chart)
- Check infusion rate correct
- Perform baseline vital signs and full GCS and limb assessment every 15mins before starting infusion
- Record BSL prior to starting infusion
Prior to starting rt-PA

1. Any concern report to nurse in charge and stroke team increase frequency of obs accordingly.
2. Do not give aspirin/heparin/warfarin x 24hrs and repeat CT scan performed confirming no further bleeding.

### Drug administration/ Dose chart

**Body weight dose chart for rTPA (Actilyse)**

<table>
<thead>
<tr>
<th>Body Weight (kg)</th>
<th>Total rTPA Dose (mg)</th>
<th>10% Bolus (ml)</th>
<th>90% IV Infusion (ml/hr)</th>
<th>No. of 50mg rt-PA vials needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-7</td>
<td>36</td>
<td>9</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>8-9</td>
<td>42</td>
<td>12</td>
<td>15</td>
<td>2</td>
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<td>10-11</td>
<td>48</td>
<td>15</td>
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<td>3</td>
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<td>12-13</td>
<td>54</td>
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<td>4</td>
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<tr>
<td>14-15</td>
<td>60</td>
<td>21</td>
<td>30</td>
<td>5</td>
</tr>
</tbody>
</table>

**Patients must be continuously monitored prior to and during drug administration, and for at least 12 hours following administration.**

1. Total dose: 0.9mg/kg.
2. Maximum dose is 90mg. (See weight/dose chart)
3. Should be prescribed by, and administration supervised by, a doctor from the stroke team.
4. 10% of total dose given as an I.V push over 2 minutes by a doctor from the responsible team.
5. Give remaining 90% of dose I.V over 60 minutes via infusion pump.
6. Observe patient for any deterioration during infusion.
POST rt-PA

Perform baseline vital signs, GCS & motor component repeat 15mins x2hrs 30mins x6hrs, 60 mins x6hrs 4 hourly for next 36 hrs

- BP Management - Maintain sbp less than 185/100 with iv labetolol/isoket
- Maintain SaO2 > 95%
- Maintain BSL < 10mmols
- Avoid nasogastric tubes, urinary catheter/central and arterial access should be avoided
- Avoid IM injections

POST TPA

- Bed rest
- Strict fluid balance chart
- Test urine/stool/ emesis for occult blood
- HDU/STROKE UNIT BED x 12-24 hrs for continuous monitoring
**Signs of possible intracranial haemorrhage**

- Any acute neurological deterioration
- Unequal pupils
- Sudden drop in GCS
- Onset of drowsiness
- Onset of nausea/vomiting
- Sometimes photophobia
- Rising BP and falling pulse
- New headache

**If haemorrhage suspected**

- Stop rt-PA infusion if haemorrhage suspected or other neurological deterioration apparent. Continue only on advise of consultant stroke physician /consultant neurologist
- Inform stroke physician/neurologist and prepare to travel for urgent ct scan
- Bloods to be drawn for coag / fbc/fibrinogen and group and hold
If haemorrhage confirmed

- Support circulatory volume with IV fluids as prescribed
- Haematology to be contacted for urgent x-match and fresh frozen plasma
- Replace clotting factors
- Neurosurgeons in Beaumont to be contacted to review CT scans

Admissions

- Pt admitted from ED with Principal Diagnosis Stoke or Cerebral Infarction

2008 – 232
2009 – 103 (Jan to June)
Complications Post Stroke

Imelda Noone, Advanced Nurse Practitioner in Stroke Care,
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Background

- Incidence of stroke ↑ with age
- Numerous studies reported assoc between age & poor outcome (Bagg, 2002, Stroke; 33:179-185)
- > 80, ↑ A fib (45% v 21.5%), ↑ mortality (27% v 9%), ↑ ENC (Noone et al. 2008, IMJ; 101:1:8-9)
- ↑ developing complications, impede rehabilitation
- Potential barriers to optimal recovery
Fastest growing segment of the pop, ↑ by 25% since 1996, 130,000 by 2011

Research to date on complications


- Langhorne P; Stott DJ; Robertson L; MacDonald J; Jones L; McAlpine C; Dick F; Taylor GS; Murray G. Medical complications after stroke: a multicenter study. (2000) Stroke, Jun;31(6):1223-9.

Complications post stroke

Cumulative proportion (% of patients experiencing complication)

- Pain
- Falls
- Depression
- Chest infection
- UTI
- Pressure sore
- Recurrent stroke

Time (weeks) from index stroke

DVT
PHYSIOLOGICAL

- **Hypoxia**: $O_2$ sats < 95% requiring supplementary $O_2$
- **Hyperglycaemia**: RBG > 11 on two separate occasions (known diabetes excluded)
- **Hypertension**: Elevated BP > 220/120 on three consecutive occasions requiring intervention (known ↑ BP on Tx excluded)
- **Pyrexia**: Temperature >37.5°C for > 24 hours for which no cause identified.

Management Physiological

- People with acute stroke should be treated to maintain a blood glucose concentration between 4 and 11 mmol/L.
- Optimal insulin therapy, which can be achieved by the use of intravenous insulin and glucose, should be provided to all adults with diabetes who have threatened or actual myocardial infarction or stroke. Critical care and emergency departments should have a protocol for such management.
- Paracetamol should be used to control pyrexia but routine use of high dose paracetamol as prophylaxis is not recommended (IV,PR,PO)
Blood pressure control

- Blood pressure reduction to 180/105 mmHg or lower should be considered in people who are candidates for thrombolysis
- Acute: Remain on reg HTN meds
- GTN 5-20 mg TOP
- 7-10 days individualised pharmacological tx
- target 135/75
- Bilateral carotid stenosis 150/90

NEUROLOGICAL

- ↓ GCS
- Stroke progression Development of new neurological deficits since initial examination
- Stroke recurrence Acute onset of a neurological deficit that cannot be attributed to the presenting lesion
- Epileptic seizure Clinical diagnosis of focal and/or generalized seizure in nonepileptic patients, supported by clear description in notes: unwitnessed blackouts, unusual turns, etc not acceptable.
Management of Seizures

- Lorazepam (Ativan®) 2mg stat IV repeated as necessary, every 2 mins to max 0.1mg/kg or
- buccal midazolam 10mg (Epistatus® liquid). May be repeated after 5 – 10 mins if necessary

If seizure stops:
- Sodium Valproate (Epilim®) 500mg IV stat (5.3mls in 100mls NaCl 0.9% over 30 mins), or Epilim chrono 500mg po stat → and commence Epilim chrono 500mg nocte po / Epilim syrup 300mg BD NG / 300mg BD PR (Delisprine®)

If seizure continues:
- Phenytoin 10 - 20mg/kg IV loading (dose usually 1000-1500mg), in 100mls NaCl 0.9% over 30 mins (can follow with further 10mg/kg (500 – 700mg) if seizure continues) → and commence Phenytoin 300mg po nocte / 270mg (45mls) NG** nocte / 300mg IV nocte

PSYCHOLOGICAL

- **Confusion** Cognitive disturbance lasting >48° documented as interfering with nursing care, rehabilitation or functional performance (e.g. verbal/ physical, aggression, wandering) (Delirium, pre-stroke dementia)

- **Depression** Low mood considered to require pharmacological or psychiatric therapy; validation of diagnosis by Psychiatrist not required
Management of Depression

- Prevalence range 17-61%
- SSRI’s – ischaemic stroke
- If dysphagic - Fluoxetine
- Mirtazapine – haemorrhagic stroke

CARDIOVASCULAR

- New onset of arrhythmia, chest pain, heart failure, worsening of pre-existing cardiac disease, new changes on ECG

- Hypotension low BP associated with symptoms (e.g. falls, unsteadiness) requiring intervention (e.g. TED stockings or alteration in drug therapy).
**INFECTION**

- **Chest infection** Inspiratory crackles and fever or radiographic evidence or purulent sputum; empirical antibiotics started for "possible chest infection" with no supportive evidence not acceptable.

- **Urinary tract infection** Clinical symptoms (dysuria/foul urine and fever) or positive urine culture (specimens reported as "mixed growth/probable contaminant" excluded; catheter specimens included only if clinically relevant); empirical antibiotics started for "possible urinary tract infection" with no supportive evidence not acceptable.

- **Cellulites** inflammation of the soft or connective requiring A/B

- **Pyrexia** Temperature >37.5° C for > 24 hours with ↑WCC, for which no cause identified

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**Management of Urinary Tract Infection**

- 11% of stroke patients
- Avoid urinary catheters
- Urinary retention
- Bladderscan
- MSU/CSU for baseline
- TWOC after 1/52
BLADDER/ BOWEL

- **Urinary incontinence** Involuntary loss of urine lasting > 48°
- **Urinary retention** Symptomatic retention requiring urinary catheterisation
- **Faecal incontinence** Involuntary loss of faeces lasting > 48°
- **Diarrhoea** Excessive and frequent evacuation of watery faeces
- **C Diff** diarrhoea with positive toxins

Bowel Care

- A bowel management programme should be implemented in stroke patients with persistent constipation or bowel incontinence.
- All patients with a loss of control over their bowels at two weeks should:
  - Have a documented, active plan of management
  - Be referred for specialist treatments if the patient is able to participate in treatments
  - Only be discharged home with continuing incontinence after the carer (family member) or patient has been fully trained and adequate arrangements for continuing supply of continence aids and services are confirmed and in place.
- Patients with troublesome constipation should:
  - Have a prescribed drug review to minimise use of constipating drugs
  - Be given general advice on diet, fluid intake and exercise
  - Be offered oral laxatives
  - Be offered rectal laxatives only if severe problems remain.
- Functional continence issues should be considered, such as access to bathrooms, management of clothing.
THROMBOEMBOLISM

- Deep venous thrombosis
- Pulmonary embolism Clinical diagnosis and imaging evidence

Management of DVT/PE

- APT, mobilise, hydration
- LMWH in prophylactic doses
- Knee high anti-thrombotic stockings in patients without significant peripheral arterial disease or skin problems.

- People with ischaemic stroke and symptomatic proximal deep vein thrombosis (DVT) or pulmonary embolism should receive anticoagulation treatment in preference to treatment with aspirin unless there are other contraindications to anticoagulation.

- People with haemorrhagic stroke and symptomatic deep vein thrombosis or pulmonary embolism should have treatment to prevent the development of further pulmonary emboli using either anticoagulation or caval filter.
PAIN

0 Limb pain In upper/ lower limb for 2 consecutive days requiring x-ray/ analgesia. Specify
0 Painful shoulder Shoulder pain requiring analgesia on 2 consecutive days (i.e. not restricted solely to the shoulder –hand syndrome).
0 Central post stoke pain.

Musculoskeletal Pain

0 Any patient continuing to experience pain should be offered pharmacological treatment with simple analgesic drugs taken regularly:
   0 Paracetamol, up to 1 g four times daily
   0 Short-term use of non-steroidal anti-inflammatory drugs (with gastric protection only if needed). Any patient whose pain is still not adequately controlled should be referred to a specialist service.
MOBILITY PROBLEMS

- **Falls** Any documented fall, regardless of cause
- **Skin break/pressure sore** Skin break or necrosis resulting from either pressure or trivial trauma (skin trauma resulting from falls not included)
- **Spasticity** An increase in muscle tone due to hyperexcitability of the stretch reflex and deep increased tendon reflexes
- **Contracture** A fixed tightening of muscle, tendons, ligaments or skin. It prevents normal movement of the associated body part and can cause permanent deformity

Management of falls

- 25% (serious injury 5%)
- Cognitive imp, innatention, anosognosia
- Falls prevention programme
  - Falls risk assessment
  - Calcium/Vit D
Pressure Area Care

- All patients unable to mobilise independently should have a pressure care risk assessment completed by trained personnel.
- Patients should be provided with a pressure relieving mattress as an alternative to a standard hospital mattress if required and reassessed as needed.
- Patients should be provided with a pressure relieving cushion if sitting out. This should be assessed in conjunction with provision of appropriate seating to reduce pressure, shear and friction forces.
  - Patients should be repositioned frequently.
  - They should have nutritional status optimised.
  - Their sacral skin should be moisturised and the skin of the incontinent patients must be kept dry.

OTHER

- **Dysphagia** Impaired swallow test requiring dietary intervention.
- **Dehydration/ renal failure** Clinical signs of dehydration supported by hypernatraemia (>148 mmols/l) or raised creatinine concentration (> 125 mmol/l or >20% if previously high). Renal failure if calculated creatinine clearance < 30.
- **Abnormal LFT’s** Requiring alteration in statin Tx.
- **Anaemia** reduction in Hb to < 10 g/dl
- **Gastrointestinal bleeding** Documented haematemesis or malaenia or positive FOB requiring medical intervention or treatment.
- **Others** Specify.
Previous studies have found a higher prevalence of TACI subtype in elderly patients which has been assigned to a higher rate of A fib.
Complications in 1st week
> 80’s versus < 80’s
Speech & Language Therapy and Stroke

Sarah Baildon
Senior Speech Language Therapist
St. James’s Hospital
Overview

- SLT and stroke: Why?
  - Swallowing Disorders
  - Language Disorders
  - Speech Disorders
- Where?
  - Acute Care settings
  - Rehabilitative settings
  - Outpatient settings

SLT Role in Stroke

- The role of the SLT in stroke rehabilitation is to provide a specialist service for clients with communication and swallowing disorders in order to improve the individual’s quality of life.
Stroke and dysphagia

- Dysphagia means an impairment of difficulty in swallowing
- Common result of acute stroke
- Affects up to 67% of all patients
- Swallowing abnormalities recover quickly in majority of cases
- Mortality rates for stroke patients with dysphagia have been reported to be 40%-63% over the first 6 months

Stroke and Dysphagia

- Associated with
  - Increased length of stay
  - Mortality
  - Poor nutritional status
  - Dehydration
  - Discharge to institutional care
Difficulties with eating/drinking/swallowing:

- Dysphagia can result in aspiration

- **Aspiration** means that food or fluid has ‘gone the wrong way’, entered the windpipe and will go into the lungs

- **Silent aspiration** occurs when the patient does not respond to material in the airway

Complications of Dysphagia

- Chest infection
- Aspiration pneumonia/respiratory compromise
- Choking
- Alternative feeding – NG-tube/PEG
- Weight loss/anorexia
- Malnutrition
- Social isolation – poor QOL
- Increased length of stay
- Death
Stroke Guidelines for Dysphagia

- Significant reduction in long term morbidity, mortality & cost of stroke care…..result(s) from the early implementation of secondary prevention strategies and the prevention of complications
- International guidelines for acute stroke recognise early management of dysphagia vital

SLT role in Dysphagia management

- Assessment and diagnosis of dysphagia
  - Oral structure/motor exam (cranial nerve assessment), clinical swallow trials (bedside/mealtime assessment), Videofluoroscopic swallow assessment or FEES
- Management of dysphagia
  - Recommendation for oral intake or NPO, and combination of: positioning strategies, dietary modification (i.e. fluid consistency/food texture modification, specific swallowing manoeuvres), rehab exercises
Clinical Indicators of dysphagia

- Coughing/choking during meals, when drinking or when taking medications
- Gurgly, wet voice
- Moist sounding chest
- History of recurrent chest infections
- Weight loss
- Food remaining in mouth at end of meal
- Inability to hold food in mouth
- Drooling
- Spiking temps with unknown cause

What can I do?

- Discuss your concerns with medical team and send a referral through to the Speech and Language Therapy Department
- Ensure the Speech and Language Therapist's recommendations are followed
- Feed the patient (if this is necessary) correctly
Stroke and communication

- Speech impairment (dysarthria, dyspraxia)

- Language impairment (dysphasia)

- Voice impairment (dysphonia)

O’Halloran et al, 2009:

- 88% patients in acute stroke units present with some type of communication difficulty.
Aphasia (Language impairment)

- Aphasia is a *Language* impairment

- Most commonly as a result of stroke to the left cerebral hemisphere

- The most common cause of aphasia is stroke. About a third of all people who have strokes develop aphasia

Aphasia cont’d

- *Comprehension* and *expression* may be affected differently in the same person

- Processing of spoken and written language may be affected

- Aphasia **does not** affect intelligence
Complicating factors in Aphasia

- Other communication impairments
- Cognitive impairments
- Perceptual difficulties
- Fatigue
- Physical difficulties
- Social and personal circumstances

Impact of Aphasia on Communication

- Competence is masked
- Exclusion from decision making
- Messages from patients are often misinterpreted
Getting the message in...

- Slow down
- Use gesture
- Keep it short and concrete
- Recap, clarify
- Write down key words
- Use prompts...maps, rating scales, pictures, objects

Getting the message out...

- Use prompts to help with decision making (incl. pointing, pictures, and objects)
- Allow time
- Use ‘unpacked’ information
- Use rating scales and pictures of emotions
- Use gesture and verbalise what you see
- Use the person’s communication book or communication aids and devices.
Dysarthria (speech impairment)

- Neuromuscular disorder of speech

- Oral communication problems due to weakness, spasticity, incoordination, involuntary movements, reduced rate and range of movement, or paralysis of speech musculature

- Language is not affected

Dysarthria & affect on communication

- Respiratory problems
- Phonatory disorders
- Articulation disorders
- Prosodic disorders
- Resonance disorders
- Reduced speech intelligibility
Dysarthria

- What can be done?
- Exercise can help strengthen muscles
- Compensatory Strategies:
  - Slowing down
  - Breaking up words
  - Communication Aids

Dysphonia (Voice Impairment)

- Voice impairment: reduced breath support, reduced loudness, harsh, hoarse, breathy voice
- Often caused by vocal cord palsy/paralysis following stroke
How can the Speech&Language Therapist help you?

- Indicate a patient's level of understanding (spoken and written) and reliability of their expression (both written and verbal)
- Explain how to communicate most effectively with the patient
- Provide communication aids and supports

Take home messages about communication

- Use clear, short sentences
- Use ALL means of communication to get your message across
- Give your patients time
- Recap and rephrase if needed
- Seek help from the Speech&Language Therapist so you can prepare
- Remember acquired communication disorders are not a reflection of intelligence
The Role of the Medical Social Worker Post Stroke

Stroke Study Day
3rd November 2009

Catherine Murphy
Medical Social Worker
St James’s Hospital
What is Social Work?

Social Work is a discipline involving the application of social theory and research methods to study and improve the lives of individuals, groups, and societies.

Social Work Training

• Degree course (Bachelor of Social Work) in TCD

• Primary degree (Bachelor of Social Science) and Masters in Social Science (Social Work) in UCD, UCC, NUIG.
Social Work Training

- Social work theories and methods
- Counselling and group work
- Statutory/legal responsibilities of social work profession
- Social policy
- Practical placement experience with intensive supervision
- Research methods - thesis

Values of Social Work

- Individualisation
- Client self-determination
- Non-judgmental attitude
- Confidentiality
- Unconditional positive regard
- Controlled emotional involvement
- Purposeful expression of feeling
Social Workers work in a variety of settings, such as:
- Child and Family Services
- Probation and Welfare
- Disability Services
- Mental Health
- Elderly Services
- Primary Care
- Voluntary Organisations
- Acute and Long-Stay Hospitals

Role of the Medical Social Worker

The role of the Medical Social Worker is to enhance people’s ability to cope
What do MSWs do?

• Provide practical & emotional support to patients and their families
• Provide a safe, confidential and supportive service
• Liaise with MDT to ensure holistic approach
• Plan discharge and coordinate community services

How?

• Provision of a direct service to patients and their families and/or carers where illness, medical care and treatment are complicated by social and emotional problems.
• Medical Social Workers work with patients on systemic and holistic levels, engaging with the patient in all aspects of their lives – individual, family and community.

• Medical Social Workers work with patients to address emotional, practical and social difficulties and assist them to develop more positive coping strategies to deal with these difficulties.
MSWs & Post-Stroke Care

• Stroke patients may need significant emotional support and specialised social work skills to assist them in adjusting to their illness or disability and help them to identify strengths and coping strategies

Emotional Impact

• Shock
• Anger
• Depression
• Anxiety
• Loss of confidence
• Loss of independence
• Impaired cognition

• Individual reaction influenced by a number of factors which are unique to every patient
Practical Impact

- Loss of independence
- Loss of income
- Change in nature of relationships
- Care needs
- Housing needs

Financial Impact

- Reduced income – often with increased financial commitments
- Eligibility for State benefits is not guaranteed
- Costs associated with home adaptations
- Costs of long term care
Impact on Relationships

- Deficits in communicating
- Loss of physical intimacy
- Family members’ anxiety
- Family members’ change of role
- Relocation to nursing home

Age-related Issues

- Under 65 v over 65
- Under 65 – lack of services as threshold generally 65+
- Over 65 – greater accessibility to benefits relating to the impact of illness
• The MSW’s broad knowledge of the social context of people’s lives and relationships enables the adoption of an holistic approach to the care of those who have experienced a stroke

MSW Skills & Tasks

• Comprehensive psychosocial assessment
• Emotional support and counselling for patients and family members
• Facilitation of communication between the patient, family and MDT
• Organisation and facilitation of family meetings and case conferences
• Patient and family education about the emotional impact of stroke
**MSW Skills & Tasks**

- Provision of information regarding financial matters
- Provision of information regarding legal issues
- Advocacy for funding and access to services
- Discharge planning
  - home with referrals to appropriate supports and co-ordination of care packages
  - residential care placement for patients unable to return home
- Case management
- Participation in relevant research

**Psycho-Social Assessment**

- Family/Living Arrangements
- Financial Situation
- Home Management
- Level of independence
- Presentation of patient
- Concerns
- Discharge Plan
Financial & Legal Matters

• Grants & Applications – housing adaptations, home care packages, carer’s allowance, illness benefit, respite grant

• Legal Matters – power of attorney, ward of court, care representative

Counselling for Stroke Patients

• Information Giving: provision of factual information and advice about hospital admission and options for discharge planning.
Counselling for Stroke Patients

• Implications Counselling: discussions with the patient and others which address the meaning of the information for the patient and takes into account the patient’s unique circumstances.

Counselling for Stroke Patients

• Supportive Counselling: the emotional consequences of implications can be expressed and acknowledged in a caring environment.
Counselling for Stroke Patients

• Therapeutic Counselling: focuses on healing, psychological adjustment, coping strategies and problem resolutions.

Additional Intervention

• Crisis intervention
• Strengths perspective/SFT
• Motivational Interviewing
• Behavioural work
• Task centred work
• Grief/loss and adjustment work.
Referrals

- Volunteer Stroke Scheme
- Alzheimer Society of Ireland
- Carer’s Association
- Home Care Package
- Respite
- Day Centres
- Home Help/Meals on Wheels

Summary: Medical Social Work Post Stroke

- Supportive role for patients
- Advice re benefits/entitlements
- Information on coping strategies
- Assessment and referral onwards if appropriate
- Practical supports – financial assistance, sourcing community services etc
Useful Websites

- www.strokescheme.ie
- www.carersireland.com
- www.irishheart.ie
- www.iwa.ie