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QUALITY OF CARE FOR PATIENTS WITH STROKE IN GREAT BRITAIN

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SUMMARY

In the past 20 years stroke has been considered the third most common cause of death in Great Britain, after cancer and heart disease. Because this disease is becoming more common every year Great Britain has worked out an advanced program of medical treatment for stroke. In the last 10 years new wards have been opened in many British hospitals, particularly for patients with strokes. Previously they were admitted to general medicine wards or to geriatric units, depending on the patient's age and concomitant diseases, such as dementia and Alzheimer's disease. In addition to stroke and rehabilitation units in British hospitals, some also have acute stroke units within the stroke ward, in order to monitor patients directly after stroke. Because many cases are fatal, a new approach to care for dying patients is also being developed. All of these aspects of quality of care for patients with stroke in Great Britain, including maintaining the patient's dignity, equality and diversity, individual preferences, cultural and religious differences will be discussed in the paper.

Key words: *stroke, holistic approach, dignity, dying, equality and diversity, accountability, confidentiality*

INTRODUCTION

Some of the patients may have significant recovery from stroke within the first month after this event. According to The Stroke Association leaflets (2007a,b) this may be a third of all people with stroke. For the vast majority of patients it may be permanent damage to brain issued in long-term disability. For some people a stroke can be fatal (*The Stroke News, 2008; When a stroke happens, 2007*).

Most of the patients with stroke need a long-term process of recovery and rehabilitation. Rehabilitation is defined as “the development of a person to his fullest physical, psychological, social, vocational, avocational and educational potential, consistent with his physiology or anatomic impairment and environmental limitations” (The Lewin Stroke and Rehabilitation Unit, Student Information and teaching package, LSRU, 2007; unpublished, p.2).

DIGNITY (CONSENT, PRIVACY)

To respect and protect patient's privacy and dignity, most medical, personal care, moving and handling procedures are undertaken behind the curtain. Each patient's area includes a bed, locker for medications and private belongings, movable table and quite comfortable armchair. There is special hanger with disposal paper curtains around each patient's area. They may be pulled on or off whenever it is necessary, e.g. during bed washing, changing pad, removing catheter, etc. The curtains are changed every two months by housekeepers and documented by the date written on it in a visible place.

Any kind of procedure taken by a member of staff should be done only with the patient's consent. Therefore, whenever a nurse is going to measure a patient's blood pressure or give him medication, they should ask for his consent. If the patient doesn't agree or doesn't give permission to begin the action, it should be documented in his notes. This consent may be verbal or nonverbal but it is essential in the hospital environment.

Each time the nurse is going to undertake medical procedure she should precisely explain to the patient what is going to happen, ensure he understands what she has said and gain informed and voluntary consent from the patient.

LIKE AT HOME (CLOTHES, POSITION)

Patients with stroke are assessed frequently and regularly on the ward by different specialists, including doctors and therapists. Whenever the patient's condition is getting better he is encouraged to wear his private clothes and sit up in bed or in the armchair during the day and especially during meal-times. This is an important part of therapy and rehabilitation. The patient may partake in washing and dressing to regain his independence. Sitting up is also

very beneficial for lungs and digestion. It protects the chest against infection, helps in better metabolism, reduces constipation and opens bowels.

Even patients with poor balance and paralysed legs can sit up in a special bucket chair (deeper than a normal armchair) which helps them to keep their balance adequately. Usually they may be moved to these chairs by two trained members of staff by using special equipment, like electrical hoist and rota stand.

All of these procedures are aimed to give the patient as more independence and self-confidence as possible soon after stroke and prepare them to go home.

EATING AND DRINKING (PATIENT'S PREFERENCES AND CHOICE)

Every patient is assessed by a speech and language therapist regarding any difficulties with eating, drinking and swallowing, which may be affected after suffering from a stroke. Every patient should have a nutrition screening tool completed weekly. Undernutrition may cause an increased risk of infection, poor wound healing, skin problems and pressure sores, cardiac difficulties, apathy, confusion, memory loss, weakness, poor mobility and motor coordination. When the patient has got some problems with eating and drinking he has a special food chart and daily fluid balance chart. Nurses or nutrition assistants record any kinds of food taken by such a patient in, or any fluid given orally or by intravascular cannula. Each ward has its own kitchen but meals are brought from the main hospital kitchen on special heated trolleys so that they may be warm for longer period of time. Patients are served food from the trolley to the dining room or to bed, depending on their conditions and preferences.

The core menu is changed every two weeks but there are some options of meal every day. Patients may make a choice according to their preferences or customs. There are some special options like: desserts for patients with diabetes or those wishing to choose a low fat, low sugar dessert, energy dense option for patients with small appetite, healthy eating, special diet (puree, soft, vegetarian, high protein, allergies, intolerances). When a patient is absent on the ward during the meal due to CT scan or other assessment, they can have their missed meal later on ordered from the main kitchen. There is also the possibility to have a lifestyle diet, according to the patient's beliefs and religion. British hospitals offer halal (Islamic food), kosher and vegan meals, but they must be pre-ordered earlier because they are prepared in strict accordance to food laws of each of this diet.

HYGIENE (INFECTION CONTROL; BARE BELOW THE ELBOW, DISPOSAL EQUIPMENT; MRSA, CLOSTRIDIUM DIFFICILE)

To maintain a high level of hygiene and to decrease the risk and probability of cross infection among patients in hospital, there are some infection control standards in British care settings, like hand hygiene, personal protective equipment, intravascular care, urinary catheter care and uniform policy. They are important to keep hospitals clean and safe for patients, staff and visitors. There are reminders everywhere in the hospital about washing hands – everybody needs to do this before coming on the ward and after going out from it. There are pictures, pictograms and posters regarding hand washing hygiene and its importance. Each member of staff is supposed to wear a uniform with bare elbows to make sure that their hands will be washed properly. Even doctors, who normally do not wear uniforms, fold the sleeves of their shirts to make them “bare below the elbow” when they are on the wards.

Personal protective equipment (PPE) is used whenever any member of staff comes to the patient’s area. The main PPE include disposal plastic aprons and latex sterile or non-sterile gloves depending on the procedure undertaken. Additionally, hands should be washed before and after each procedure. Millions of gloves and aprons are used in hospital every day.

As for intravascular cannula care, the line site should be checked at least once a day to determine it is clean, dry and free from signs of infections. To access hubs, ports etc. aseptic non-touch technique (ANTT) should be used each time. Clean dry, sterile and transparent dressing should be changed appropriately.

Urinary catheter care needs some standard procedure as well. Before and after every catheter manipulation hands needs to be washed. The date and time of insertion of catheter should be documented in the patient’s notes. Check catheter care should be performed at least once a day and documented. Drainage catheter system should be sterile and closed, tubing and bag should be placed below the level of the bladder and the catheter bag should be kept off the floor.

Each member of staff is trained regarding the awareness of patient’s susceptibility and to realise the factors or increase the risk of infection, e.g. immunity (immuno-compromised), age (elderly and very young), physical and psychological wellbeing (seriously ill), underlying disease and medical intervention.

Because many patients after stroke have problems with swallowing and they are nil by mouth, there is a risk of mouth infection. Therefore, the patients’ mouth care is strictly maintained by staff on stroke and rehabilitation wards. Special mouth tablets are used to clean the patient’s mouth, tongue and throat regularly, even every two hours a day.

A swap of secretions should be taken from the throat, groin and nose of every new admitted patient regarding MRSA. If the test is positive (the bacteria are present and active in his skin) he is immediately separated from the other patients as barrier nursing in order to protect others from cross infection. A similar procedure is taken against clostridium difficile, which is especially dangerous for weak and poor patients treated with antibiotics. Unfortunately, these two sources of infections are detected in British hospitals quite often but on the other hand, due to infection control standards they are less frequently occurring every year.

UNIFORM POLICY

All members of hospital staff participate in duties reflect professional image. There is a long tradition concerning this matter in Great Britain, beginning from school uniforms, which are very popular for students, and which no one argues with. Employees in the UK are used to working in their uniforms. There some practical reasons for wearing them. First of all, clothing should be compatible with safe moving and handling. It is supposed to be appropriate to the area of undertaken work with minimizing the risk of infection transfer from patient to patient and within the hospital. Secondly, uniforms protect staff from hazards. Thirdly, it is a promotion of professional appearance to patients, relatives and visitors. Uniforms are supposed to be cleaned and changed daily to prevent the risk of cross infection. They should not be worn outside the hospital. There is a hierarchy and structure of staff which may be pointed out by the colour of kind of uniform. Basically, there are dresses with black tights or tunics, with dark trousers for female and garments with trousers for male. There are strict rules regarding many details, like

- a) staff's hair (off the face, neat),
- b) fingernails (clean, short),
- c) jewellery (only wedding ring),
- d) shoes (only black, flat, enclosed toes and heels),
- e) watches (they must not be worn because they impede proper hand washing and increase the risk of injury during moving and handling).

Any exceptions or repeated disregard of this policy is considered as misconduct and it could lead to disciplinary action. Additionally to the uniform, staff must wear identification badges, which should be visible. In order to promote professional appearance staff must refrain from chewing gum and smoking on duty or in uniform. The whole hospital area is a smoke-free area which means that all staff, patients, relatives and visitors must adhere to the No Smoking Policy in and around the hospital (UPDC, 2005).

HOLISTIC APPROACH TO PATIENT AND HIS REHABILITATION

The stroke team is made up of a lot of different kinds of specialists trained in caring for people with having had a stroke. This really large multidisciplinary team may include two groups of people: 1) a stroke care team formed by members of staff for everyday care in hospital, like doctors (consultants, registrars and specialists), nurses, healthcare assistants, nutrition assistants, and 2) a rehabilitation team consisting of occupational therapists, speech and language therapists, physiotherapists, assistant practitioners, neuropsychologists. The team cooperates efficiently because every member of staff is responsible for patients' personal care to be able to notice and report any abnormalities or meaningful changes in their condition (Hospital Review of the Year, 2007; LSRU, 2007; Stroke and Rehabilitation, 2007).

DYING (LCP)

Many of the patients after a stroke are getting better and regain their independence after long rehabilitation but a stroke may also be fatal and some of the patients will die because of it. To care for dying patients at the end of their life The Specialist Palliative Care Team at the Royal Liverpool University Hospital developed an Integrated Care Pathway (ICP), called Liverpool Care Pathway (LCP) as well (Ellershaw, Wilkinson, 2003). The main purpose of using LCP is to protect the patient's dignity, to give the family confidence in the area being delivered. This tool is applied for patients diagnosed as dying when they meet at least two of the following criteria: a) bed-bound, b) semi-comatose, c) only able to take sips of fluids (or nil by mouth for an extended period of time), d) no longer able to take tablets, e) pain, f) agitation and restless, g) respiratory track secretions, h) nausea and vomiting, i) breathlessness (dyspnoea) (Watson, Lucas, Hoy, Back, 2005). The LCP has been developed in order to transfer the hospice model of care into hospitals and other care settings. There are three sections of LCP: 1) an initial assessment made on diagnosing the dying person; 2) ongoing assessment; 3) care after death (Fallon, Hanks, 2006).

CONFIDENTIALITY

All of the information about a patient in hospital is regarded as strictly confidential. They are kept in the patient's folder and nobody can read them without his consent.

On the other hand, the patient has a right to know about his condition and standards of confidentiality. Patient's notes should be kept secure. There are some instructions concerning different types of information, like paper information, electronic, telephone, answer machine, email, and fax machine.

ACCOUNTABILITY

Nurses and doctors are accountable to the professional body that means they are responsible for the patient's health and any mistakes. Moreover, all members of staff are accountable to themselves, their employer and the patients. The staff is accountable for the action undertaken and for any omissions. To be accountable, the staff needs to keep themselves up-to-date with policies and required training, to report poor practice and standards, act as an advocate for the patient, work in collaboration with other members of team and act according to job description, having done only what is including in it.

CONCLUSIONS

The approach to treatment and rehabilitation of patients with stroke in Great Britain is complex, complicated and holistic but there are some advantages and disadvantages of such an approach. Firstly, there is an ideal situation for rehabilitation but sometimes even this does not work to the uttermost and doesn't let patient be independent as before the stroke. This kind of work as a multidisciplinary team protects members of staff from being independent and making wrong decisions. On the other hand, it also makes the responsibility for the patients blurred because everybody is responsible for everything. Finally, costs of such a treatment are tremendous, so it is difficult to follow this pattern for less rich and developed countries.

Apart from rehabilitation of people with strokes, The Stroke Association (SA) popularizes prevention guidelines as well (www.stroke.org). There is some useful information which may help to educate regarding the prevention of stroke, like to know your own blood pressure and keep it under control, to find out if the person has an irregular heart rhythm (atrial fibrillation) which may increase the risk of stroke, to stop smoking, to drink alcohol only in moderation, to check your own cholesterol level regularly, to exercise daily, to eat healthily etc. A broad national campaign has also been run on the early main symptoms of stroke to familiarize society with them in case of the necessity to help themselves or other people. The most popular and easy test is called FAST. (Face Arm Speech Test – see also: Nor et al., 2004). The name of the test is meaningful as well because the first 24 hours may be crucial for a person's health and length of further treatment and rehabilitation. Therefore, it is important to look for professional attention after a stroke as soon as possible.

A way to approach quality of care for patients with stroke in Great Britain may be summarized as holistic because it involves a multidisciplinary team and includes care "from head to toe". Another way which is also apparently visible in the hospital is the equality and diversity policy. Acting according to equal opportunities includes strategy to promote equal access and treatment. This policy is based on the principles of providing an environment of respect and dignity for all people.

Diversity describes the strategy to promote values, behaviour and working practice which recognize differences between people and enhances staff motivation, performance and potential to treat people differently according to their needs and preferences, regarding the individuality which should be expressed and developed.

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