



Nursing concise guide for stroke 2016

This profession-specific concise guide contains recommendations extracted from the National Clinical Guideline for Stroke, 5th edition, which contains over 400 recommendations covering almost every aspect of stroke management. The reference number of each recommendation is provided so that they can be found in the main guideline www.strokeaudit.org/guideline. The recommendations below have direct implications for nurses. This concise guide should not be read in isolation, and as members of the stroke multidisciplinary team, nurses should consider the guideline in full.

Specialist stroke services

2.3.1J Acute stroke services should have an education programme for all staff providing acute stroke care (including ambulance services and the emergency department as appropriate) and should provide training for healthcare professionals in the specialty of stroke.

2.3.1K Acute stroke services should participate in national and local audit, multi-centre research and quality improvement programmes.

Resources

2.4.1B A hyperacute and/or acute stroke service should provide specialist medical, nursing, and rehabilitation staffing levels matching the recommendations in Table 2.1.

2.4.1K A facility that provides treatment for in-patients with stroke should include:

- > a geographically-defined unit;
- > a co-ordinated multi-disciplinary team that meets at least once a week for the exchange of information about in-patients with stroke;
- > information, advice and support for people with stroke and their family/carers;
- > management protocols for common problems, based upon the best available evidence;
- > close links and protocols for the transfer of care with other in-patient stroke services, early supported discharge teams and community services;
- > training for healthcare professionals in the specialty of stroke.

Acute stroke

3.10.1A Patients with acute stroke should be admitted directly to a hyperacute stroke unit with protocols to maintain normal physiological status and staff trained in their use.

3.10.1B Patients with acute stroke should have their clinical status monitored closely, including:

- > level of consciousness;
- > blood glucose;
- > blood pressure;
- > oxygen saturation;
- > hydration and nutrition;
- > temperature;
- > cardiac rhythm and rate.

3.10.1C Patients with acute stroke should only receive supplemental oxygen if their oxygen saturation is below 95% and there is no contraindication.

3.10.1D Patients with acute stroke should have their hydration assessed using multiple methods within four hours of arrival at hospital, and should be reviewed regularly and managed so that normal hydration is maintained.

3.10.1E Patients with acute stroke should have their swallowing screened, using a validated screening tool, by a trained healthcare professional within four hours of arrival at hospital and before being given any oral food, fluid or medication.

3.10.1F Until a safe swallowing method is established, patients with dysphagia after acute stroke should:

- > be immediately considered for alternative

- > have a comprehensive specialist assessment of their swallowing;
- > be considered for nasogastric tube feeding within 24 hours;
- > be referred to a dietitian for specialist nutritional assessment, advice and monitoring;
- > receive adequate hydration, nutrition and medication by alternative means.

3.10.1.G Patients with swallowing difficulties after acute stroke should only be given food, fluids and medications in a form that can be swallowed without aspiration.

3.10.1.H Patients with acute stroke should be treated to maintain a blood glucose concentration between 5 and 15 mmol/L with close monitoring to avoid hypoglycaemia.

Transfers of care

2.6.1A Transfers of care for people with stroke between different teams or organisations should:

- > occur at the appropriate time, without delay;
- > not require the person to provide information already given;
- > ensure that all relevant information is transferred, especially concerning medication;
- > maintain a set of person-centred goals;
- > preserve any decisions about medical care made in the person's best interests.

Positioning

3.11.1B Healthcare professionals responsible for the initial assessment of patients with acute stroke should be trained in how to position patients appropriately, taking into account the degree of their physical impairment after stroke.

3.11.1C When lying or sitting, patients with acute stroke should be positioned to minimise the risk of aspiration and other respiratory complications, shoulder pain and subluxation, contractures and skin pressure ulceration.

Early mobilisation

3.12.1A Patients with difficulty moving after stroke should be assessed as soon as possible within the first 24 hours of onset by an appropriately trained healthcare professional to determine the most appropriate and safe methods of transfer and mobilisation.

3.12.1B Patients with difficulty moving early after stroke who are medically stable should be offered frequent, short daily mobilisations (sitting out of bed, standing or walking) by appropriately trained staff with access to appropriate equipment, typically beginning between 24 and 48 hours of stroke onset. Mobilisation within 24 hours of onset should only be for patients who require little or no assistance to mobilise.

Deep vein thrombosis and pulmonary embolism

3.13.1A Patients with immobility after acute stroke should be offered intermittent pneumatic compression within 3 days of admission to hospital for the prevention of deep vein thrombosis. Treatment should be continuous for 30 days or until the patient is mobile or discharged, whichever is sooner.

Continence

4.5.1A Stroke unit staff should be trained in the use of standardised assessment and management protocols for urinary and faecal incontinence and constipation in people with stroke.

4.5.1B People with stroke should not have an indwelling (urethral) catheter inserted unless indicated to relieve urinary retention or when fluid balance is critical.

4.5.1C People with stroke who have continued loss of bladder and/or bowel control 2 weeks after onset should be reassessed to identify the cause of incontinence, and be involved in deriving a treatment plan (with their family/carers if appropriate). The treatment plan should include:

- > treatment of any identified cause of incontinence;
- > training for the person with stroke and/or their family/carers in the management of incontinence;
- > referral for specialist treatments and behavioural adaptations if the person is able to participate;
- > adequate arrangements for the continued supply of continence aids and services.

4.5.1E People with stroke with constipation should be offered:

- > advice on diet, fluid intake and exercise;
- > a regulated routine of toileting;
- > a prescribed drug review to minimise use of

constipating drugs;

- > oral laxatives;
- > a structured bowel management programme which includes nurse-led bowel care interventions;
- > education and information for the person with stroke and their family/carers;
- > rectal laxatives if severe problems persist.

Hydration and nutrition

4.7.1B Patients with acute stroke should be screened for the risk of malnutrition on admission and at least weekly thereafter. Screening should be conducted by trained staff using a structured tool.

4.7.1E Patients with stroke who are at risk of malnutrition should be offered nutritional support. This may include oral nutritional supplements, specialist dietary advice and/or tube feeding in accordance with their expressed wishes or, if the patient lacks mental capacity, in their best interests.

Falls

4.9.3.1A People with stroke should be offered falls risk assessment and management as part of their stroke rehabilitation, including training for them and their carers in how to get up after a fall.

4.9.3.1B People with stroke should be offered an assessment of fear of falling as part of their falls risk assessment.

Mood and well being

4.10.1.1B People with or at risk of depression or anxiety after stroke should be offered brief psychological interventions such as motivational interviewing or problem-solving therapy (adapted if necessary for use with people with aphasia or cognitive problems) before considering antidepressant medication.

4.10.1.1C People with mild or moderate symptoms of psychological distress, depression or anxiety after stroke should be given information, support and advice and considered for one or more of the following interventions:

- > increased social interaction;
- > increased exercise;
- > other psychosocial interventions such as psychosocial education group

Oral care

4.11.1A People with stroke, especially those who have difficulty swallowing or are tube fed, should have mouth care at least 3 times a day including:

- > brushing of teeth and cleaning of gums with a suitable cleaning agent (toothpaste and/or chlorhexidine dental gel), for which an electric toothbrush should be considered;
- > removal of excess secretions;
- > application of lip balm.

4.11.1C People in hospital or living in care homes after stroke should receive mouth care from staff trained in:

- > assessment of oral hygiene;
- > selection and use of appropriate oral hygiene equipment and cleaning agents;
- > provision of oral care routines;
- > awareness and recognition of swallowing difficulties.

Pain

4.12.2.1A People with musculoskeletal pain after stroke should be assessed to ensure that movement, posture and moving and handling techniques are optimised to reduce pain.

Sex

4.14.1A People with stroke should be asked, soon after discharge and at their 6-month and annual reviews, whether they have any concerns about sex. Partners should also have an opportunity to raise any problems.

Swallowing (use in conjunction with 3.10.1)

4.16.1J People with stroke should be considered for gastrostomy feeding if they:

- > need but are unable to tolerate nasogastric tube feeding;
- > are unable to swallow adequate food and fluids orally by four weeks from the onset of stroke;
- > are at high long-term risk of malnutrition.

Further rehabilitation

5.9.1.1A People with stroke, including those living in a care home, should be offered a structured

health and social care review at six months and 1 year after the stroke, and then annually. The review should consider whether further interventions are needed, and the person should be referred for further specialist assessment if:

- > new problems are present;
- > the person's physical or psychological condition, or social environment has changed.

5.9.1.1C People with stroke should be provided with the contact details of a named healthcare professional (e.g. a stroke co-ordinator) who can provide further information and advice.

5.9.1.1D People with stroke should be helped to develop their own self-management plan.

End of life care

2.15.1B Staff caring for people dying of stroke should be trained in the principles and practice of end-of-life care, including the recognition of people who are approaching the end of life.

2.15.1C Decisions to withhold or withdraw life-prolonging treatments after stroke including artificial nutrition and hydration should be taken in the best interests of the person and whenever possible should take their prior expressed wishes into account.

2.15.1D End-of-life (palliative) care for people with stroke should include an explicit decision not to impose burdensome restrictions that may exacerbate suffering. In particular, this may involve a decision, taken together with the person with stroke, those close to them and/or a palliative care specialist, to allow oral food and/or fluids despite a risk of aspiration.

2.15.1E People with stroke with limited life expectancy, and their family where appropriate, should be offered advance care planning, with access to community palliative care services when needed.

Carers

2.16.1D When care is transferred out of hospital to the home or care home setting, the carer of a person with stroke should be offered:

- > an assessment of their own needs, separate to those of the person with stroke;
- > the practical or emotional support identified as necessary;
- > guidance on how to seek help if problems develop.

Rehabilitation approach - goal setting

2.10.1A People with stroke should be actively involved in their rehabilitation through:

- > having their feelings, wishes and expectations for recovery understood and acknowledged;
- > participating in the process of goal setting unless they choose not to, or are unable to because of the severity of their cognitive or linguistic impairments;
- > being given help to understand the process of goal setting, and to define and articulate their personal goals.

2.10.1C People with stroke should be supported and involved in a self-management approach to their rehabilitation goals.

Psychological care - organisation and delivery

2.12.1C Services for people with stroke should provide training to ensure that clinical staff have an awareness of psychological problems following stroke and the skills to manage them.

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