Cwm Taf University Health Board 6 Month Assessment undertaken by Specialist Stroke Nurses within the community setting

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Overview of Service

A 6 month assessment provides a person with a stroke a review with a trained professional to determine how patients are coping and adapting following their stroke. The review will also determine whether they need to make changes to their lifestyle or medication and whether further therapy is needed. The 6 month assessment is also a review of the level of disability and an opportunity for the patient to discuss any new or ongoing difficulties that they are experiencing physically, emotionally, psychologically, financially or socially. It must be stated that the Cwm Taf service follows and supports all stroke patients beyond the 6 month assessment period and much of the work for the staff involved is associated no just with the actual "review" but of signposting, working closely with a range of agencies within health, social care and the voluntary sector and generally providing an holistic, patient centred and seamless service throughout acute, rehabilitation and community care.

The service consists of 1 Band 7 and 1 Band 6 full time Stroke Specialist Nurses covering a five day a week service (Monday to Friday). There is also a part time Administration Support Worker who is based in the community with close working links with members of the acute stroke service, Early Supported Discharge Service as well as rehabilitation wards in the community hospitals.

The nurses have rapid access to:

- Dietetics
- Stroke consultants

With good established working relationships with General Practitioners, the Stroke Association, Special Ophthalmologists, Social Service Reablement Services in Merthyr Tydfil and Rhondda Cynon Taff, therapy outpatient services across Cwm Taf and a range of Public Health Wales locally provided services such as smoking cessation.

How the service operates and has improved service provision

Most referrals are generated from the acute, rehabilitation and discharge planning wards within Cwm Taf. The community stroke nurse attends the weekly multi-disciplinary meeting on the stroke ward to screen and receive appropriate patients.

When the referral is received patients are contacted, usually within two weeks of receiving the referral (sooner if they are ESD patients) and a face to face follow up is arranged. This follow up always happens within six weeks of discharge. All patients are provided with a name and contact number to phone if needed while waiting for their appointment.

Face to Face contact

During the patient's first face to first contact with the specialist stroke community nurse, they will discuss the diagnoses of the stroke and explain in further detail, to help patients and their families understand, what has happened to them. Risk factor management, secondary prevention and

lifestyle changes are also discussed to help the patient adjust to life after stroke. Baseline outcome measures are recorded (Bartel, MRS, etc).

Families and carers are offered carer's assessments to support them with their current and future needs in providing continuing care for the stroke survivor. This includes all aspects of care from physical, emotional, psychological, financial and social.
After visiting the patient their details are put into a database and the stroke nurse will visit or telephone dependant on need.
Patients are encouraged to contact the stroke nurse on the numbers provided if they need any queries answered.

Six month Assessment

Usually these assessments are completed over the telephone, however if the patient needs a face to face appointment due to any form of difficulty this will be arranged. If requested by the patient, contact is also made with family members so that information given is correctly relayed. This assessment includes conducting a mood screening, medication review, secondary prevention, physical and social changes, lifestyle and environmental changes, and checking with the patient if there is any other support needed and onward referrals to health, social and voluntary agencies.

Summary of benefits of the service for patients and families

- Increased Quality of Life (QoL) and mood.
- Empowers the patient to manage their own medical condition.
- Increased participation in rehabilitation in patient's own environment.
- Increased integration back into the community.
- Improved social participation.
- Rehabilitation at home in a familiar environment promotes functional recovery.
- Patient is seen at home so they do not need to come into hospital for an appointment.
- Patients are provided with a contact name and number between the hospital and community.

Current Research for Service Improvement and Delivery:

The Community Stroke Nurses and ESD Community Team Co-ordinator are currently participating in "Assessment of Patient Reported Health Status Questions via Four Different Methods of Administration, in Stroke Survivors: A Randomised Controlled Trial".

This research commenced 10th July 2017, with the aim to identify and establish what would be the best route of 6 month follow up assessment from a patients perspective. As part of the 6 month review, this research study will assess the response rate for 15 patient reported health status questions across the 4 recognised methods of delivery;

1. Face to face
2. Telephone
3. Online
4. Post

Patient Case Study:

Background: Normally a fit gentleman, married with adult children and grandchildren. He is employed as a Health and Social Care Assessor. Patient is a driver.

Referral received 28.12.16
1st contact telephone call: 4.01.17
Face to face visit: 6.01.17