New ways of working in stroke care

Examples of new or extended roles for those involved with the care of stroke victims and their carers

First edition, August 2002
INTRODUCTION

The Changing Workforce Programme has been set up to promote new ways of working which will both improve patient care and be more attractive to staff. “New ways of working” covers a variety of approaches to job redesign: new roles may be created or existing roles may be adjusted to include additional responsibilities. These new or changed roles will probably cross traditional demarcations: between individual professions, between registered and support staff, between clinical and non-clinical staff and between health and social care.

New types of job are needed for a variety of reasons:

- traditional roles do not always fit the needs of patients. For example, several people may be involved in a patient’s care - the tasks required could be combined into a single role so that the patient relates to fewer staff, there is a quicker service and is less likelihood of miscommunication
- there are staff shortages in nearly every professional group
- there is a competitive labour marker and fewer young people are coming into healthcare
- there are pressures on staff time such as the European Working Time Directive for junior doctors

The Changing Workforce Programme is developing a radical approach to job redesign through a number of channels:

- pilot sites across the Country, currently numbering 13, in which role changes in respect of a particular clinical condition or a specific staff group are tested in detail.
- the Toolkit for Local Change, a process which enables a healthcare provider to address service challenges through the creation of new roles
- a database of new jobs which have been introduced across the Country working at a national level on significant blockages

One of the pilot sites concerns the care of stroke patients. This publication is a compilation of examples of new ways of working in stroke care which have been introduced by a range of providers. The aim is to illustrate how new roles can meet patients’ needs more effectively, while at the same time giving staff more opportunities to develop their skills and experience. Some are unique to one site, whereas others have been introduced in a number of places; in the latter case, one or two examples are included for illustration.

A few of the roles included here are not new but have been in existence for some time. They have been included as examples of jobs which have moved away from traditional demarcations of work.

The following need particular explanation:

Community rehabilitation teams

There are several examples of Community Rehabilitation Teams in the UK. These are multidisciplinary teams which usually include physiotherapists, occupational therapists, speech and language therapists and nurses. There may be input from a clinical psychologist, usually part-time if at all. It is common for there to be generic support staff who are able to carry out treatment plans devised by any of the main therapy professionals. CRTs may also include a
social worker/care manager and home care staff, and the team may have its own store of minor equipment to avoid delays in supply.

Although the purpose of all CRTs is broadly similar, they may intervene at different stages of the care pathway. Their aims may include the avoidance of hospital admission, speeding up hospital discharge through involvement while still in hospital, short term support in a community hospital and at home, and providing longer-term support. In structural terms a CRT may be part of the Intermediate Care service, in which case the team’s involvement may be limited to around 6 weeks. The purpose of the team therefore needs to be made clear to users, service managers and commissioners.

The Community Rehabilitation Team Network can be contacted on 01785 271100 or helenj.pearce@nsch-tr.wmids.nhs.uk.

Reference: Improving community rehabilitation teams for people with stroke. JML Geddes British Journal of Therapy and Rehabilitation March 2001 vol 8 no. 3 p 92

Stroke Co-ordinators

The term Stroke Co-ordinator may refer to a role focussed at either an overall service level or at the level of individual patients.

In the former case the post holder’s role is likely to include developing and implementing protocols/guidelines or the care pathway, promoting audit and research, supporting education and facilitating interdisciplinary working.

The latter type of stroke co-ordinator acts as a specialist clinical resource. They may review the care of patients on various hospital wards and co-ordinate the transfer of care through the various stages of the patient journey. They may also be involved in activities such as leading a follow-up clinic. This type of role is described in Standard 5 of the National Service Framework for Older People as the “stroke care co-ordinator”, which could be “a specific post or a role that any team member could undertake”.

The two functions are distinctly different, though in practice some individual appointments combine service development with supporting individual patients.

Help to introduce new ways of working

The Changing Workforce Programme can help organisations to develop new roles in order to address specific service challenges. This is could be done through our “Toolkit for Local Change”, a process built around a facilitated workshop which engages representatives of staff at all levels in designing roles which can be tested and evaluated. Increasingly facilitators trained in using the Toolkit are available locally, and can often be contacted through Workforce Development Confederations.

A comprehensive set of guidance notes will be available shortly which organisations can use to develop new ways of working.

The Changing Workforce team is also happy to receive enquiries through its central offices in London and Leeds:

London: 020 7210 5732
Leeds: 0113 254 6587
Additional examples of new ways of working in stroke care are welcome for inclusion in future editions of this publication. Please contact:

Philip Shields  
Workforce Designer  
Changing Workforce Programme  
Room G19a  
Richmond House  
79 Whitehall  
London SW1A  

e-mail philip.shields@doh.gsi.gov.uk  
phone 01482 466028  fax 01482 654256
AMBULANCE STAFF – ACUTE STROKE INTERVENTION

North West Stroke Task Force

Contact: Caroline Watkins 01772 893713  cwatkins@uclan.ac.uk

The NW Stroke Task Force are currently training ambulance personnel in BASICS (Basic Acute Stroke Intervention and Care Strategies) alongside other acute and primary care trust staff. There are 14 afternoon sessions across the NW Region for staff locally, which will be followed by one of two full days to meet their needs as identified at the first sessions. The evaluation of this mini module has thus far been excellent with many staff keen to encourage their colleagues to travel to forthcoming meetings in order not to have missed out on the experience.

The incorporation of ambulance personnel in these sessions has proved invaluable in both their own understanding of acute stroke care, but also for other staff in understanding existing and proposed systems of care.

see the website  www.nwstroketaskforce.org.uk

CLINICAL SPECIALIST – STROKE SERVICE

Nottingham City Hospitals Trust

Contact: Dawn Good  0115 969 1169  dgood@ncht.org.uk

The purpose of the post is to co-ordinate stroke services within the Trust in conjunction with the lead clinician for stroke medicine. Tasks include:

- developing and monitoring standards and guidelines
- providing leadership to the multidisciplinary team
- developing a training strategy
- representing the Trust in relation to partner organisations
- promoting audit and research in stroke services

At a clinical level she acts as a specialist resource, co-ordinating the care of those patients not originally admitted into the stroke service. In the stroke clinic her role involves secondary prevention.

COMMUNITY NURSE FOLLOW-UP

Sheffield PCTs

Contact: Amanda Jones  0114 2261141  e-mail  Amanda.Jones@sth.nhs.uk

A comprehensive referral form is sent to the community nursing service following the rehabilitation period. All stroke patients are reviewed at home by a community nurse 6 months after discharge from hospital.

The nurse will screen for:

- carer and family issues
- continence
- depression using the HAD instrument
- functional ability using the Barthel instrument
- medication, BP, blood glucose, cholesterol and other medical issues as appropriate
- nutritional status
- pressure areas
- smoking cessation
- social and environmental issues
- speech
- swallowing

The information is returned to the Single Point of Access to enter on a database, and any appropriate action is initiated.

COMMUNITY REHABILITATION SERVICE

Northumberland

Contact: Marie Watkins  phone 01670 533881  e-mail: mwatkins@northumberland.gov.uk

There are 4 community rehabilitation teams for stroke and other neurological conditions. Each team has a co-ordinator (chosen from any relevant profession: it includes a clinical role), therapists and generic rehabilitation workers. The rehabilitation workers have a background in either health or social care. They have a full-time training programme lasting 6 weeks based on defined core competencies; they then work towards the NVQ Promoting Independence (level 3).

The service is offered for upto 12 weeks post-discharge, and can be highly intensive: upto three visits per day. Clients have been found to make rapid progress due to the level of input (qualified therapists could only visit about twice per week). The rehabilitation assistants monitor day to day progress, and report back to the qualified staff.

COMMUNITY REHABILITATION SPECIALIST NURSE – YOUNGER NEUROLOGICAL PATIENTS

Leeds Community Rehabilitation Unit

Contact: Louise Elwen  tel  0113 305 5080

The Unit admits patients under 65 with neurological disorders for intense rehabilitation in the post-acute phase; around half are stroke victims. Patients are admitted from home or residential care. The role of the nurse is to smooth the transition into rehabilitation services: she does a home assessment, plans the admission, reassures the patient, solves problems associated with admission and aims to understand the patient’s problems as fully as possible. The nurse also follows up after discharge where necessary and acts as an ongoing point of contact.

The role draws on the disciplines of physiotherapy, occupational therapy and social work in addition to nursing.
COMMUNITY REHABILITATION TEAMS

Community Health Sheffield

Contact: Mike Dalton or Reuban Steele  0114 271 6145  e-mail  crtne@chsheff-tr.trent.nhs.uk

These provides an effective alternative to hospital-based rehabilitation and enable patients to go home much earlier. There are four teams which serve mainly stroke and orthopaedic patients.

Members: physiotherapists, OTs, SALTs, psychologist, social workers, therapy assistants.

They provide dedicated home care including daily treatment for upto 3 months. They have their own stock of equipment.

COMMUNITY STROKE REHABILITATION TEAM

Dartford, Gravesham and Swanley PCT

Contact: Stuart Jeffery, team co-ordinator  01474 574206  e-mail ICTeam@dgs-pct.nhs.uk

The team has been set up to allow patients to be moved from an acute hospital bed at the earliest opportunity. Referrals are also accepted directly from GPs so that patients can be managed without acute hospital admission. Patients are cared for either at home or in a community hospital. The team comprises the co-ordinator (from a nursing or therapy background), physiotherapists, OTs, SALTs, dietitians, nurses, a care manager, generic rehabilitation assistants and an administrator.

The average length of stay in an acute bed has been reduced from 23 to 16 days.

The strength of the team is in the intradisciplinary working. The generic assistants have a focus with a therapist but are able to provide a therapy assistant role, albeit at a lower level, for the other therapies: for example the SALT-based assistant will visit a patient to do the SALT work and then move on to do some physio. This extends to the therapists and nurses as well with the easier home visits being performed by nurses, cross working on perceptual problems by OT and SALT etc. The rehab assistants also provide personal care and support for patients to allow for earlier discharge rather than waiting for a care package.


CREATIVE THERAPIST

Castle Care Nursing Home, Hull

Contact: Simon Wright  01482 879334  e-mail  A247simon@aol.com

Simon Wright has a degree in psychology and social work and a diploma in therapeutic counselling. He combines a variety of techniques with stroke patients, individually and in groups. Activities include IT-based learning, creative therapy, reminiscence, counselling, relaxation therapy and physiotherapy. The nursing home, owned by Barchester Healthcare, has a person-centred approach which has helped stroke victims to achieve an active and satisfying lifestyle.
DIETITIANS MANAGING PEG FEEDING

Royal Hallamshire Hospital, Sheffield

Contact: Chris Rudd, Dietetic Manager  0114 271 2645   e-mail chris.rudd@sth.nhs.uk

A dietitian has been appointed who will have a broader role supporting patients with PEG feeds. Working across the hospital, the dietitian will visit patients in their home or in the community setting, monitor and deal with any problems which arise and review the need for ongoing enteral feeding.

A complementary service development is the involvement of nurse endoscopists in the fitting of the PEG.

DYSPHAGIA NURSE SPECIALIST

Queen Elizabeth Hospital, Gateshead

Contact: Steve Davies    0191 403 2844    e-mail s.r.davies@ncl.ac.uk

The Dysphagia Nurse Specialist (DNS) is an advanced practitioner in dysphagia management and has a clinical, educational and training role. The DNS is responsible for organising basic training of ward staff (including doctors), as well as seeing and providing an initial opinion on the majority of swallowing referrals. This intermediate ‘trouble-shooting’ function allows the SALTs more time to fulfil their consultative role for more difficult and complex cases. It has also enabled SALTs the opportunity to devote more time to language work and has been directly responsible for a marked decrease in the outpatients waiting list for language referrals.

Certificated training is offered at two levels for healthcare professionals:
Level 1: enables the screening and identification of swallowing problems coupled with appropriate referral of patients for more detailed assessment by the DNS or SALT. This level is designed primarily for the health care professionals who are working in areas that do not have a large numbers of dysphagic patients.
Level 2: at this level health care professionals are trained to both screen and manage patients suffering from routine, non-persistent dysphagia, (non-persistent is defined as resolving in less than 2 weeks); this level is designed for nurses working in areas that have a larger number of dysphagic patients e.g. Medical Admissions Unit, Stroke Units.

DYSPHASIA SUPPORT ORGANISER - THE STROKE ASSOCIATION

Contact: Mo Wilkinson, Assistant Director of Community Services,
The Stroke Association, Worthington House, Hope Hospital,
Stott Lane, Salford, Manchester, M6 8HW
Tel: 0161 707 6143
e-mail: mwilkinson@stroke.org.uk

Dysphasia Support aims to help people who have communication difficulties following a stroke to attain the maximum possible level of recovery and independence in language skills through home visits and weekly group meetings. Staffing within the local service is provided by one or more Dysphasia Support Organisers who recruit, train and support a group of volunteers who offer practise with effective communication skills. The service is provided under contract to local health and social care purchasers and is organised through the regional offices of the Stroke Association. Dysphasia Support is complementary to the work of speech and language therapists and new services are always set up with their agreement and help.
EMOTIONAL SUPPORT TO STROKE PATIENTS AND CARERS

Bradford

Contact: Philip Shields 01482 466028 e-mail philip.shields@doh.gsi.gov.uk

Patients, carers and staff in stroke services frequently report that too little attention is paid to the psychological consequences of stroke. In fact there is evidence that staff may shy away from such problems because they feel unable to deal with them.

Staff who come into contact with stroke patients and their carers will be helped to extend their roles beyond purely physical care through acquiring additional skills and understanding. Two levels of training will be provided. Level 1 will be called “The Experience of Stroke” and will concentrate on the personal experiences of survivors. Level 2 training will be a course at the University of Bradford on Solution Focussed Therapy: a psychological skill which can be applied in the course of everyday work with patients. There will be ongoing supervision for staff trained in these ways.

ENABLEMENT WORKER

Bradford

Contact: Heidi Caine or Trudi Bean 01274 675431

Experience showed that the positive gains of rehabilitation in hospital were not sustained by home care staff because they tend to do things for their clients rather than encouraging clients to do things for themselves. The Enablement Project has trained a group of home care staff to act in “rehabilitation mode”, fulfilling much the same role as the generic rehabilitation assistants in hospital. Care staff in the rehabilitation wing of one Social Services care home have also received this training.

An evaluation study has demonstrated the positive benefits of the role in maintaining the level of clients’ functioning after discharge from hospital. Most of the staff are enthusiastic about the role, which gives them more opportunities to develop their skills and careers.

Eventually it is hoped that the enablement workers and the hospital-based therapy assistants will become one pool of staff.

The enablement workers are currently receiving training from district nurses so that they will additionally be able to undertake some simple nursing tasks, thus reducing the number of staff involved with a given patient.

FACILITATED DISCHARGE TEAM

North Tyneside

Contact: Val Blacklock 07775 800 905
Early Facilitated Discharge was piloted in 1997 within the North Shields area of North Tyneside. The Scheme went Trust-wide six months later. The service is for stroke only.

The team consists of:

1 full time H Grade (Co-ordinator)
1 full time Senior Physiotherapist.
1 full time Senior Occupational Therapist.
1 Part Time (25hr) OT Assistant
0.2 Speech & Language Therapist
16 Generic Support Workers working a range of hours
1.5 social workers

All generic support workers are trained or are working towards level 2 NVQ. Some have attained level 3. Generic support workers carry out all therapies (OT, Physio & Speech & Language) prescribed by a therapist in hand-held documents within the patient’s home environment; they also do housework.

There is a foundation course in stroke for non-qualified staff and the ENB 923 Professional Development in Stroke Care course for all qualified staff within the multi-disciplinary team.

FAMILY SUPPORT ORGANISER – THE STROKE ASSOCIATION

Contact: The Stroke Association 020 7566 0300 website www.stroke.org.uk

Family Support is a visiting service providing practical information and emotional support to the families and carers of people who have had a stroke, and to those affected by stroke who live alone. The service is provided, for up to one year, under contract to local health and social care purchasers and is organised through the regional offices of The Stroke Association. Family support does not replace the skills of health and social care professionals, but provides a complementary service to assist families in making the psychological adjustments they will have to make as a result of stroke.

The service has been shown to provide positive benefits to carers.

Reference: Jonathan Mant The Lancet 8 May 2002

GENERIC OUTREACH WORKERS

Northallerton: Hambleton & Richmondshire PCT

Contact: Elaine Rooney 01609 764819 erooney@nahs-tr.northy.nhs.uk

Generic workers visit patients and carers after leaving hospital, continuing goal setting and providing basic support. They work closely with fellow professionals: clinical psychologists, nurses, speech and language therapists, OTs and physiotherapists. The team leader is an occupational therapist. All the generic workers rotate between the ward and the community, which appears to be changing attitudes surrounding ageism and disability.

There is now empirical evidence that this service reduces the length of stay and improves outcomes.
HANDY PERSON SCHEME

Barnet, North London

Contact: Dennis Lam, Handy Person Co-ordinator, Age Concern Barnet
020 8203 5040   e-mail barnethendon@ageconcern.org.uk

This pilot scheme is available to older people who are unable to complete minor household repairs themselves. The types of work covered include minor electrical repairs, joinery, small plumbing jobs etc. It is not meant to replace an occupational therapy assessment. Materials have to be paid for but there is no charge for labour.

HEALTH PROMOTION ACTIVITY FOR CARERS

Ulster Hospital, Dundonald, Northern Ireland

Contact: Sandra Aitcheson, Ward Manager, Stroke Unit  028 9048 4511 ext 2238
e-mail sandra.aitcheson@ucht.n-i.nhs.uk

In this Stroke Unit there are health promotion and risk factor assessments for the spouses of patients, as they are at risk of developing strokes themselves, i.e. primary prevention in a secondary care environment. These are well accepted and highlight problems which staff were unaware of.

The ward is currently implementing Patient Diaries which include information about the type of stroke, the reasons, risk factors, rehabilitation goals and discharge plan: the aim is to improve patient and carer knowledge about stroke and the management of risk factors.

INTERACT READING SERVICE

Barnet, North London: Finchley Memorial Hospital

Contact: Shirley Pullenayegum  020 8346 2375

In the “Interact” reading service, professional actors read to patients: this has been found to be more effective than using lay readers. Three sessions of two hours per week are provided, resourced from Lottery funding. The service provides patients with stimulation and entertainment.

LIAISON HEALTH VISITOR

Leeds Community and Mental Health Trust

Contact: Carol Walker   tel 0113 295 1400/1424

Liaison health visitors follow up stroke patients from admission, through inpatient rehabilitation and into the community for the first year after discharge home. Their perspective is community-
orientated; they aims to alleviate stress in the patient and family, ensure that requested services are delivered and they continue with health promotion activities. One the main benefits of the role is being able to deal with new problems that arise after discharge from hospital.

Reference: The role of liaison health visitors in rehabilitation of stroke patients after discharge. Health Visitor vol 70 no 9 p347 September 1997

**NURSE-LED FOLLOW UP CLINIC**

**Sheffield Teaching Hospitals**

**Contact:** Amanda Jones  0114 2261141    e-mail  Amanda.Jones@sth.nhs.uk

Patients attend the clinic 8-10 weeks after leaving hospital. The clinics are run by the stroke nurse consultant. The following are considered:

- secondary prevention
- the patient’s physical/medical status
- their functional abilities
- social and environmental issues
- the patient’s mood
- carer and family issues

**NURSE PRACTITIONER – STROKE CARE**

**North Tyneside General Hospital**

**Contact:** Norma Tindle  0191 259 6660 ward 20
norma.tindle@northumbria-healthcare.nhs.uk

The role includes:

- Medical assessment of patients
- Ordering tests e.g. X rays, ECGs
- Technical procedures usually carried out by junior doctors e.g. intravenous lines
- Co-ordination of patient care
- Swallowing assessments

The benefits of this role include:

- Saving junior doctor time
- Prompt care for patients
- Improved continuing of care for patients
- Education of other staff

**NURSE SPECIALIST - STROKE**
Salford

Contact: Stephen Cross 0161 787 1283
stephen.cross@srht.nhs.uk

This nurse specialist post comprises a number of roles:

- reviewing the care of stroke patients on various acute wards in the hospital
- leading a follow-up clinic 6 weeks post-discharge from the stroke rehab unit
- health education for patients as part of secondary prevention
- staff education about stroke for nursing, medicine and AHPs
- participation in research programmes
- service development: protocol development, funding bids

OUTREACH OCCUPATIONAL THERAPIST – YOUNGER STROKE PATIENTS

Leeds

Contact: Margaret Bonsall 0113 392 4523

The Stroke Rehabilitation Scheme is an outreach occupational therapy service for younger stroke patients. It is jointly funded by Leeds Teaching Hospitals Trust and Leeds Social Services. The occupational therapist trains and oversees a small bank of support workers.

The service aims to ease the stroke victim’s transition from hospital to home, and to promote the restoration of occupational performance skills through home-based therapy tailored to his/her needs and those of the immediate family. There is no time limit on the period of involvement.

PATIENT FINANCIAL ADVISOR

Bradford

Contact: Ann West 01274 365473 e-mail annwest7543@aol.com

Hospital social workers complained that they were spending a large part of their time assessing patients’ financial means prior to a package of care being provided. Also patients were not receiving any welfare benefits advice. It has been decided to pilot a new role on the stroke unit which will combine these tasks. The advantages will be a better package of financial advice to patients and saving social workers’ time.

PHYSIOTHERAPIST – EXTENDED ROLE IN STROKE REHABILITATION

Leeds

Contact: Barbara Greenwood, Ward 10, Chapel Allerton Hospital tel 0113 392 4595

Physiotherapists educate and advise nursing staff in therapeutic handing and general aspects of stroke care in formal and informal situations. This helps to make all activities therapeutic.
The physiotherapists and occupational therapists have started weekly evening sessions for carers in which they represent the whole team. The meetings feed back from the weekly case conference, covering care, goals, current and future plans etc.

REHABILITATION ASSISTANT

see “Therapy Assistant”

RETIRED AND SENIOR VOLUNTEER PROGRAMME

Barnet, North London: Finchley Memorial Hospital

Contact: Shirley Pullenayegum  020 8346 2375

The Retired and Senior Volunteer Programme is a national scheme of voluntary work for over 50s, part of the national charity Community Service Volunteers. In this case the volunteers aim to meet the social needs of stroke patients in hospital. Selection of volunteers is done jointly between RSVP and the hospital, and training is then provided. Volunteers work for 3 hours per week covering activities such as writing letters for patients, social activities, quizzes, bingo, reminiscence, art and outings.

There are 20 volunteers in the hospital, supported by two paid co-ordinators who work 10 hours per week.

SELF-ADVOCACY GROUP

Hull and East Yorkshire

Contact: Strokewatch  01482 783112  e-mail: strokesurvivors@hotmail.com

A group of stroke survivors and carers in Hull and East Yorkshire have formed a self-advocacy group known as “Strokewatch”. The group has actively campaigned for better local stroke services and two years ago succeeded in persuading the Health Authority to fund a specialised stroke unit. The group continues to monitor the quality of services through its membership and through feedback forms given to all patients. Members of the group were recently invited to form a user involvement subgroup of the district stroke strategy committee.

SENIOR CARER – STROKE REHABILITATION UNIT

Hull

Contact: Sarah Halford, Rossmore Nursing Home, 68 Sunnybank, Hull  01482 343504

Rossmore is a private nursing home which contains an NHS-funded stroke rehabilitation unit. The senior carer in the unit devises patients’ care plans in conjunction with the registered nurse, supervises the care assistants and carries out treatment plans drawn up by OTs and physiotherapists.
SINGLE POINT OF ACCESS TO STROKE SERVICES

Sheffield Teaching Hospitals

Contact: Clare Doyle   0114 2261222/223   e-mail Clare.Doyle@sth.nhs.uk

A dedicated phone line is run by a stroke nurse specialist and clerical co-ordinator, and provides GPs and other health professionals with a single point of access in the case of TIAs or suspected strokes. From the single point of access the nurse can arrange hospital admission, give information advice as necessary about various services such as community rehabilitation, or arrange for an appointment at the rapid stroke assessment clinic. The nurse specialist runs 3 clinics per week. It’s a one-stop clinic; the patient has a series of tests which include a CT head scan, carotid duplex, routine bloods and an ECG. The nurse will then discuss their pre-morbid status, medications, BP and assess if the patient requires any further support such as community rehabilitation, or in some cases hospital admission.

STROKE COUNSELLOR

Devon

Contact: Jackie Byrne 01392 402509

The stroke counsellor makes contact with patients and families in the early stages of the stroke and ensures that they have understood the information given by other health professionals. She offers emotional support and conveys specific issues to the MDT meeting. In the fast-tract clinic for minor strokes (which is consultant-led), she sees patients and carers after the doctor, provides literature and discusses the impact of the stroke on their life.

Relative support groups are held every fortnight. There are also support groups in the community provided mainly for couples, which run for 9 weeks and provide support and education. Formal counselling on a one-to-one basis is provided to patients on an outpatient basis; this is also available to carers where they are finding it difficult to cope. The stroke counsellor works closely with the clinical psychologist, who also provides supervision.

The service has been running since 1989.

STROKE NURSE CONSULTANT

Sheffield Teaching Hospitals

Contact: Amanda Jones 0114 226 1141  amanda.jones@sth.nhs.uk

The aims of the nurse consultant have been to co-ordinate stroke services ensuring more equity of care in the city by initiating an integrated care pathway for stroke. The role involves running stroke review clinics, acting as a point of contact for specialist advice, supporting the stroke nurse co-ordinators, developing protocols in hospital (the hospital pathway is now nurse led), providing teaching sessions on both pre and post registration courses and initiating the first stroke care course for nurses in Sheffield. The nurse consultant takes a lead with the stroke strategy. In addition she is working with primary care addressing primary prevention and implementing a process for community based nurses to carry out 6 monthly reviews. She is
developing personal health records and stroke information packs and is involved in the single record of stroke documentation; she is also part of the national Clinical Guidelines for Stroke working group. Providing support to carers by setting up various support groups has been another useful facet of the role.

The benefits of the role have been the creation of equity of access across the city and addressing gaps in the service. The role is clinically-based giving expert advice to other staff both locally and, regionally and nationally.

**STROKE NURSE CO-ORDINATOR**

*Sheffield Teaching Hospitals*

**Contact:** Sue Barnston  0114 271 1833  e-mail Sue.Barnston@sth.nhs.uk

Five stroke nurse co-ordinators are located in two acute hospital sites. Their role is to operationalise the care pathway by co-ordinating the transfer of care through the various stages of the journey. They visit emergency units daily and record all stroke admissions. They undertake screening for swallowing as well as dysphagia management, administer stroke information packs and personal health records, and initiate the movement of patients through the care pathway. They follow the patient out to the community and give specialist input to the rehabilitation team. Also give information to health professionals, patients and carers in both hospital and the community e.g. advice on diet, exercise, BP, medication.

**STROKE PREVENTION SERVICE ADVISOR**

*Hull*

**Contact:** Chris Rennison, Stroke Association Business Manager  01482 830440  
 e-mail crennison@stroke.org.uk

The Stroke Association in partnership with the local Health Action Zone and Social Services Department is piloting two prevention projects for people who have experienced either a TIA or who have had a first stroke to help them reduce risk factors. The service offers information to patients and carers on prevention, and works with individuals to develop a proactive lifestyle change programme for up to 6 months. Home visits are combined with groupwork such as smoking cessation, exercise to music and healthy eating.

**STROKE TRAINING CO-ORDINATOR**

*Chest, Heart and Stroke Scotland*

**Contact:**  Anne Crawford  0131 225 6963  e-mail anne.crawford@chss.org.uk

Internet:  [www.chss.org.uk/strokecourses.htm](http://www.chss.org.uk/strokecourses.htm)

This role was created in response to evidence of the need for better staff education in this area. The training co-ordinator provides education and training events and resources for health professionals in relation to stroke. Short courses are provided at introductory, intermediate and advanced level.
The post was located and managed within this voluntary organisation to avoid association with a single NHS Trust, and it is funded by the Lothian Health Board.

**SWALLOWING ASSESSMENT BY NURSES**

**Bradford**

**Contact:** Trish Summersgill 01274 365632/365683 e-mail stroke.unit@bradfordhospitals.nhs.uk

Nursing staff have been trained in swallowing assessment due to the shortage of Speech and Language Therapists. This is becoming common practice in many parts of the Country. Training and ongoing supervision is usually provided by SALTs. It may also be possible for nursing staff to attend an appropriate post-registration course at a University.

*see also Dysphagia Nurse Specialist*

**THERAPY ASSISTANT (also known as Rehabilitation Assistant)**

**Bradford**

**Contact:** Carol Rhodes 01274 365234 e-mail carol.rhodes@bradfordhospitals.nhs.uk or Jill Gregson 01274 364251 e-mail jill.gregson@bradfordhospitals.nhs.uk

Therapy assistants are able to support physiotherapists, occupational therapists and SALTs. They are trained to a set of competencies and provide a seven day service.

In Bradford there are therapy assistants in orthopaedics, the vascular ward, the stroke unit and wards for older people. There has been a significant reduction in the length of stay in hospital, for example from an average of 16 days to 9 days for hip replacement; this is largely due to the increased amount of therapeutic activity. A conscious choice has been made not to combine the role of therapy assistant and healthcare assistant, as it is felt that acute nursing needs are likely to assume precedence.

Reference: Cutting it fine Health Service Journal 12 April 2001 p28

**YOUNGER STROKE SURVIVORS’ DEVELOPMENT WORKER**

**Bradford**

**Contact:** Jan Bloor or Linda Owers 01274 495442 e-mail lili.france@bradford.gov.uk

Local stroke survivors said that the needs of younger people were not being met – they felt existing services were built around older people. Two staff at Whetley Hill, a day centre for physically disabled people, have taken on the role of development worker for younger stroke survivors. An open meeting advertised for stroke victims aged under 65 was attended by 20 patients together with some carers, with guests from the national organisation Different Strokes and Hull Strokewatch. Participants identified a number of areas where they wanted help: sporting activities, relaxation, sexuality etc. Most people who attended were keen to come again and to play an active part in planning further events.