Stroke

"We have been involved in discussions and processes to remodel services; these have transformed what happens. A new strategy has been produced, and the benefits are seen in better informed services, in which patients are treated as individuals, not stereotypes."

A number of factors influenced how well older people recovered following a stroke. For example, the Stroke unit trialists' collaboration (2003)[18] showed that spending time on a specialist stroke unit greatly improved outcomes in terms of death, dependency and the need for institutional care. Hospitals in three of the communities that were inspected did not have such a stroke unit open at the time of the inspection. People who had had a stroke in these communities were cared for on general wards with support from the specialised stroke team. A national sentinel stroke audit carried out by the Royal College of Physicians in 2004, published in March 2005, shows that 82% of hospitals in England have a stroke unit[20], also more people are treated in a stroke unit for part of their hospital stay compared to the previous year. In the communities that were inspected services were not always integrated across health and social care.

In some areas access to diagnostics was still problematic. MRI (magnetic resonance imaging) scanners which use radio frequency waves and a strong magnetic field rather than x-rays to provide clear and detailed pictures of internal organs and tissues – a valuable tool for diagnosing stroke – were not always fully staffed, leading to delays. In most places there was good integrated working, with timely acute assessment and rehabilitation following a stroke, and smooth transition from hospital to home.

Rehabilitation and advice

Rehabilitation and support services based in community were established or were being developed in all areas, with evidence of good links with acute units and effective interagency working providing a rapid response service. Many older people and their carers spoke highly of such services, particularly the input from therapists and the speedy provision of equipment and adaptations to the home to enable independent living. However, follow up by GPs was not always as effective as it might be. Medication was not always explained clearly, and some carers said that GPs were often unaware of the caring role and responsibilities they undertook.

Several people singled out the Stroke Association for praise, mentioning the information provided and its excellent volunteers who helped people navigate through the complex system for benefits. One older person commented "when illness strikes people are at a low ebb and least able to cope with the bureaucracy involved in accessing services and benefits. Skilled help at such a time is vital and valued". A survey carried out by the Healthcare Commission and the Royal College of Physicians[21] in 2005 found that almost one third of patients who wanted information from health and social services about stroke said that they had not received any since they left hospital.

A national sentinel stroke audit carried out by the Royal College of Physicians in 2004 found that 65% of people who were admitted to hospital had a physiotherapy assessment within 72 hours of admission and 52% had an assessment by an occupational therapist

Key messages

Overall, the picture for comprehensive services around stroke was improving, with evidence of strong clinical leadership and good development of both acute services and those based in the community.

There was equal access to services for people who have had a stroke regardless of age. Some older people made a specific reference to this as they appreciated that there was no age barrier to appropriate care and treatment for a stroke.

All communities inspected provided an acute specialist stroke service.

Three of the communities inspected did not provide a stroke unit.

All of the communities inspected had agreed protocols for the referral and management of people who had experienced a mini stroke.

Not all of the communities inspected had stroke registers to identify people at risk of a first or subsequent stroke.

There were inconsistencies in the way the communities that were inspected implemented protocols to prevent a first or subsequent stroke.

The services used by people who have suffered a stroke and their experiences in using these services is the subject of this section. The NSF has a standard on stroke services. It is aimed at all people who have had a stroke and is not related to age. This section is not restricted to the national service framework standard on stroke. Stroke was used as a lens through which to assess services against all the national service framework standards and themes during inspections. It was clear that a lot of effort had gone into improving services for people who have had a stroke, and older people had been part of the process. In some cases, older people had helped to redesign services, with very positive outcomes. In Redcar and Cleveland, for example, a stroke care coordinator was appointed in response to older people identifying areas where their needs had not been met, and, in Medway, older people had not only been involved in a major redesign of services, but were part of a process to ensure that services continued to improve.

Also in Medway the use of a diary was regarded as a valuable and effective means of communication between older people, their relatives and friends. The diary could help them to remember questions or comments for staff, and to feel more involved in their own care and treatment.

Specialist services for people who have had a stroke

All general hospitals caring for people who have had a stroke in the communities that were inspected provided an acute specialised service and operated according to clinical guidelines approved by the Royal College of Physicians.