National Stroke Nursing Forum
Nurse Staffing of Stroke Early Supported Discharge Teams
A Position Statement for Guidance of Service Developments

Introduction
This paper is a position statement from the National Stroke Nurses Forum (NSNF) on the role of the Registered Nurse in Early Supported Discharge (ESD) Teams.

The Guidance has been prepared collating information from research evidence of trials on ESD in Stroke that report on nurse staffing, information from current early supported discharge services in England, and the CLAHRC Consensus paper. The Forum acknowledges that there is a lack of evidence on appropriate staffing levels linked to patient outcome in Stroke Community Teams. Therefore evidence has been augmented with:

- Expert consensus of lead stroke nurses across the United Kingdom
- Evidence of the nursing contribution to rehabilitation
- Opinions from ESD teams in the UK on the nursing needs of their patients.

The aim of this paper is to provide general guidance on the role of the nurse in community stroke teams (including ESD teams), and nurse staffing levels, based on the 'principles of best practice'. This guidance is based on a very limited research evidence base, and has been produced using the consensus of experts within the stroke nursing profession with evidence where available.

The Forum recommends that further research is undertaken to examine the relationship between nurse staffing levels and patient outcome in community stroke rehabilitation.

Summary of recommendations
Early supported discharge (ESD) schemes have been shown to have comparable outcomes and costs to conventional Stroke unit care (Early Supported Discharge Trialists, 2005). The National Stroke Nursing Forum recommends that all ESD Schemes include a component of Senior Specialist Nursing time (Band 6) in addition to stroke-skilled nursing time, at 1.5 to 2.0 wte to manage 100 patients per year, with 7 days a week service provision. This will ensure the provision of the essential nursing needs listed in appendix 1.

Background
ESD schemes have been shown to have comparable, if not better, outcomes to conventional inpatient stroke specialist rehabilitation (Early Supported Discharge Trialists, 2005).

ESD Teams Composition
Most ESD teams have been developed in urban areas, and comprise of a multidisciplinary team, coordinated through regular meetings. From research evidence available, the most benefit from ESD seems to be those patients with mild to moderate disability (Langhorne et al, 2005).

In current practice, and in the research evidence, all ESD teams comprised of physiotherapy and occupational therapy, with a minority having Speech and Language Therapy, Medicine and Nursing (Langhorne et al, 2005; Portsmouth, Sheffield, Worthing, North Down & Newcastle Community Stroke Teams). Registered nursing levels in these teams varied significantly from 0 to 2 whole-time equivalents for a case load of 100 patients per year.

The unique role of the registered nurse in community stroke rehabilitation
The therapeutic contribution of the nurse in stroke rehabilitation remains poorly researched, however it is acknowledged that there is a unique contribution to be made by the nurse in stroke rehabilitation (Burton, 2003, Nolan & Nolan, 1998). Common problems after stroke reported by patients at home contain a wide range of nursing needs including personal hygiene, pain, mood, medication and incontinence (Murray, Young and Forster et al, 2006). Nursing within a community stroke rehabilitation team can enable the patient to be looked at holistically, working towards true re-enablement, and not just re-enablement of the functional aspects of care (McGinnes et al, 2010).

The unique nursing contribution described in community stroke rehabilitation teams are:

1. Physiological monitoring
2. Medication management and concordance
3. Continence assessment and management
4. Nutrition & Hydration
5. Pain management
6. Wound management
7. Secondary prevention
8. Psychological care
9. Therapy ‘carry-on’
10. Communication and co-ordination
11. End of Life Care

(McGinnes et al, 2010, see Appendix 1 for a more detailed description)

The Forum considers it ‘best practice’ that the nursing needs of stroke patients receiving ESD should be provided by a nurse who has specialist knowledge of stroke care, equivalent to what they would be receiving if the patient was rehabilitated as an inpatient on a stroke unit. Nurses with specialist stroke knowledge are able to integrate the essential, generic nursing needs (e.g. wound care) with the specialist needs of a patient rehabilitating from a stroke (e.g. pressure relieving equipment and seating needs after stroke). This includes the impact of changes in the patient’s condition on their rehabilitation programme, and the registered nurse working within the multidisciplinary team to structure their rehabilitation programme accordingly.

Position statement
There are numerous specialist stroke nursing roles in the community, for example Stroke Co-ordinators; Stroke Liaison Nurses; Community Matrons specialising in Stroke; and Consultant Nurses. The recommended nursing levels stated below assume that the ESD service **does not** have access to any specialist stroke nursing input, apart from what is included in the ESD Team.

It is recommended that local services perform a scoping exercise of current community stroke specialist nursing provision in their area, and adjust the nursing levels of the ESD team accordingly. However the NSNF recommends that any community stroke specialist nursing role is fully integrated into ESD Team to ensure effective and efficient multidisciplinary working, and continuity of care on discharge from the ESD team.

The level of patient dependency is based on the admission criteria from the meta analysis of ESD teams (Early Supported Discharge Trialists, 2005). It is recommended to have 1.5 to 2.0 whole time equivalents (WTE) to manage 100 new patients per year, with the assumption that nurses will have 20 hours direct patient contact time each week, with service provision 7 days a week.

The NSNF recommend that nursing bands are majority Band 6 or above, which reflects specialist stroke skills, the extended therapeutic skills, and regular independent working. Larger ESD teams with several nursing roles may be able to support more Band 5 levels within their team.

References

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November 2012

Appendix 1

The Role of the Nursing in Community Stroke Rehabilitation

1.	Physiological Monitoring
	a. Prevention / early detection of post stroke complications.
	b. Cardiovascular monitoring.
	c. Blood sugars / diabetic monitoring.
	d. Respiratory function.
	e. Venesection.
2.	Medication management and concordance
	a. Monitoring effects (therapeutic & side effects) of new medications.
	b. Self medication assessment (including cognitive assessment).
	c. Patient/Carer/Family education.
	d. Liaison with GP and local pharmacies.
3.	Continence assessment and management
	a. Assessment and management of bowel and bladder problems.
	b. Bladder scanning.
	c. Screening for urinary infection.
	d. Education and training to the patient/carer/family.
	e. Liaison with Continence Service, GP and District Nurse for ongoing care
4.	Nutrition & Hydration
	a. Nutritional & hydration assessment, monitoring intake.
	b. Dysphagia monitoring.
	c. Education of patients/carers/family for those with modified consistency diets or high nutritional risk.
	d. Liaison with Speech and Language Therapy, Dietician and GP.
5.	Pain management
	a. Assessment and monitoring, in particular those with communication or cognitive problems.
	b. Liaison with therapy team of pain impacting on rehabilitation interventions.
	c. Implementation of pharmacological and non pharmacological interventions.
6.	Wound management
	a. Wound assessment and management.
	b. Tissue viability assessment.
	c. Liaison with District Nurse/GP for ongoing care.
	d. Education of patient/carers on tissue viability.
7.	Secondary prevention
	a. Risk factor assessment and monitoring.
	b. Education on medication for secondary prevention.
	c. Integration of healthy lifestyle changes into rehabilitation programme.
	d. Liaising with GP on risk factor modifications

8.	Psychological care
	a. Supportive/counselling role.
	b. Supporting wider family/carers.
	c. Carer strain assessment.
	d. Mood assessment and monitoring (including drug therapies).
	e. Management of fatigue
9.	Therapy ‘carry-on’
	a. Integration of therapeutic principles into nursing care
	b. Continual re-assessment of patient’s condition, and subsequently altering rehabilitation interventions.
10.	Communication and co-ordination
	a. Working effectively within a specialist multidisciplinary team, which epitomises quality stroke rehabilitation.
	b. Support and integration of wider non specialist health and social care professionals.
	c. Supporting patient/spouse on sexuality and relationship needs.
	d. Education of patient/carer/family and MDT on surgical interventions and investigations for stroke.
	e. Planning essential nursing care needs, including the supervision and education of unregistered nursing care/rehabilitation assistants on essential nursing care and the integration of rehabilitation interventions.
11.	End of life care