There is consensus that acute stroke nursing has made great strides in recent years with the increase in hyperacute and specialist units. But with a national report on stroke care showing nurse staffing levels and access to specialist community services varying widely, there is still much to do, say leaders in stroke nursing.

The State of the Nation Report on Stroke Services and Care, published in December by the Royal College of Physicians (RCP), combines two reports from the Sentinel Stroke National Audit Programme (SSNAP). The SSNAP acute organisational audit (RCP 2014a) measured staffing levels, resources and facilities, while the first SSNAP annual report (RCP 2014b) explored the care of 74,000 patients treated between March 2013 and April 2014 (see panel).

The SSNAP has been measuring real-time data on stroke patient care against national guidelines, published in quarterly reports on the RCP website since February 2014.

While staffing levels have increased, specialist training is not keeping pace with demand. Louise Hunt reports

The organisational audit noted that average staffing levels for nurses and care assistants have increased from a median of eight per ten stroke unit beds in 2012 to nine in 2014. But this may not be enough as skill mix and training are still too variable, the audit found.

RCN long-term conditions adviser Amanda Cheesley agrees with the findings: ‘The ratio of registered nurses needs to be sufficient to provide the skilled nursing input that people who have had a stroke need. All staff need to have had training in the management of people with an acute stroke and be able to provide high quality and effective care 24/7.’

‘There is still poor training, especially for healthcare assistants, and a reliance on bank or agency staff at weekends and at night, so continuity of care is compromised. In the early acute phase of treatment all staff need specific training and the skill mix needs to be weighted on the registered nurse side.’

The organisational audit also highlighted concerns about weekend staffing levels. The recommended minimum staffing ratio is three qualified nurses on duty at all times during the day for every ten stroke beds. But currently only 50 out of 183 hospitals (27%) have this number on duty at weekends.

Nursing Older People reported (Hunt 2014) on research that showed stroke death rates are higher where there are fewer nurses and a clear link between higher nursing numbers and lower mortality for stroke patients.

The SSNAP audit called for units with below-average staffing to address this issue as a matter of urgency.

Chair of the National Stroke Nursing Forum (NSNF) Clare Gordon says although there has been more scrutiny of nurse staffing levels since the Francis Inquiry, the recommended nurse/patient ratio needs to be rethought.

‘Our concern is that the recommended levels [for stroke care] are based on patient dependency which doesn’t take into account releasing staff for multidisciplinary meetings, training or for research,’ Ms Gordon, who is stroke nurse consultant at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, says. ‘There is a need to look at the bigger picture. Some places are not even achieving the recommended staffing levels.’

Ms Gordon says the NSNF is updating its guidance on staffing levels based on new evidence.

Swallow assessment

The audit also stressed the importance of patients being assessed by a nurse specially trained in managing stroke within 24 hours of admission, and found that 86% of patients received this assessment.

A swallow assessment, usually conducted by a speech and language therapist or specially trained stroke nurse, happened for 78% of patients within 72 hours. ‘The importance of a swallow assessment cannot be underestimated,’ Ms Cheesley says. ‘In the past when this had to be undertaken by a speech

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and language therapist delays often resulted which compromised the patient’s health, caused avoidable distress to the patient and relatives and indeed could result in harm such as dehydration and malnutrition. This emphasises the need for specialist skills which many nurses have.

High-tech units
Stroke nurses agree that more attention should be paid to ensuring nurses are equipped with the specialist skills required on today’s high-tech stroke units. ‘There is wide variation in nursing levels, skill mix and training,’ says Ms Gordon.

‘Our biggest concern is that nurses are having to meet demand much quicker but do not necessarily have the specialist training needed in stroke.’

Professor of stroke and older people’s care at the University of Central Lancashire Caroline Watkins agrees: ‘We don’t have rigorous steps that are enforced in developing stroke specialist skills.’ As this issue of Nursing Older People went to press, the UK Stroke Forum was planning to relaunch the website for its stroke-specific education framework to make it easier for staff to identify training needs.

Although burdensome, it is acknowledged that participating in the SSNAP is contributing to service improvements. ‘It can show the difference between apparently well-staffed units and those that are not and use it as ammunition to get more staff,’ Professor Watkins says. ‘But also it can look at what is not being achieved in those that are well staffed.’

Lead nurse for stroke at York Teaching Hospital NHS Foundation Trust Carol Croser adds: ‘The SSNAP has certainly helped to drive up standards here where we have increased nurse staffing levels and are slowly moving to seven-day working. It means there is something to look at if you need additional resources and the pace of change has been significant.’

Community care varies
However, the transition from hospital to community remains problematic for many patients.

Access to stroke-specific early supported discharge (ESD) teams that aim to provide the same level of specialist care in the community has continued to increase from 44% in 2010 to 74% in 2013/14. One quarter of patients are discharged with some support from an ESD team, but this should be offered to all appropriate patients. Access to specialist nursing, speech and language therapy and psychological support in the community also varies considerably.

Ms Cheesley attributes these results to a reluctance to move resources from acute to community care. ‘Specialist stroke nurses tend to be based in secondary care and so are not always able to support community staff,’ she says.

‘But where there are services they are popular, effective and have good outcomes. I would like to see everyone who has a good prognosis seen by such a team, including those living in care homes.’

Patients requiring long-term specialist community rehabilitation saw an increase in availability - with 131 hospitals (72%) having access compared with 108 (57%) in 2012, but almost 30% of patients reported having no access to specialist community rehabilitation.

Ms Gordon says lack of investment in community services is a reflection of where stroke service development has been prioritised and the number of specialist nurses in the community is low.

‘Community care at rehabilitation stage has been championed by therapy, but I would argue that you need specialist nursing to support the therapies,’ she adds.

She hopes that the ‘National Conversation’ project launched in December by the NSNF, which aims to capture how nursing roles in stroke are evolving, will help to make more explicit the contribution of specialist stroke nursing in community care. The findings will be published in June.

Louise Hunt is a freelance writer

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