Different approaches to stroke care in Finland and in the UK

Caroline Lawson, winner of the Nuffield Trust joint international travel award 2008, travelled to Finland to observe stroke services. Here she describes how she plans to implement the good practice witnessed on the trip.

Summary
This article describes the experiences of a nurse and manager, winners of a joint travel award to explore stroke services in Finland. It aims to encourage nurses to undertake exchanges and visits, overseas or in their own countries.

Keywords
Education: overseas, educational visits, health care abroad, European Union

THE NUFFIELD Trust, one of the leading independent health policy charitable trusts in the UK, has in the past awarded a joint travel award which provided nurses and managers with an opportunity to undertake joint study tours in the UK or overseas.

Last year I successfully applied for the award and used the funding to travel to Finland, a country that is recognised worldwide for its excellent acute stroke service.

The award links nursing and management so I invited Alan Bartle, the south west regional manager for the Stroke Association, to join me. Our aims were to examine how the hyperacute phase of stroke is managed, particularly thrombolysis, and establish what the voluntary sector offers people who have had a stroke.

We hoped to be able to return to the south west region with some new ideas for developing stroke services.

A detailed itinerary was planned with the help of our contacts in Finland. Our main contact was Johanna Martin, a neurological specialist nurse, who helped us with the Helsinki part of the trip. Ms Martin is the only specialist nurse, in any field, in the 2,000-bed Helsinki University Meilahti Hospital.

Stroke management in Finland
Although Finland’s demographics are comparative with the NHS South West region – the total population of both is around five million – when it comes to stroke management there appear to be more differences than similarities.

One fundamental difference, for example, is that the Finnish public have a basic understanding and awareness of medical conditions including stroke and transient ischaemic attacks. This is because general first-aid training and health promotion awareness are offered to all members of the public over the age of 15 by the National Defence Training Association of Finland.

The morning nursing routine is another notable difference. Although the staffing levels at the Helsinki University Meilahti Hospital and the Laakson Hospital rehabilitation unit are comparable to Yeovil District Hospital, the patients’ daily routines seem different. To start with, all patients are up and dressed by 10am every morning.

While this provides a good routine for the patients and promotes their recovery, we were unsure how their fundamental hygiene needs were being met. It transpires that the patients do not receive a full wash every day. Instead they have a shower rota, so patients get a full shower every four days and have a ‘quick wash’ on days in between.

The nurses explained that this is more like patients’ home life and that frequent washing could make their skin more friable and at risk of breaking down. For patients at the Laakson Hospital
rehabilitation unit breakfast in bed is not an option. Everyone has breakfast either at the table in their three-bed bay or in the unit’s dining room, and staff believe that this has reduced the incidence of chest infection and the risk of aspiration.

Acute management
Finnish health care has an interventionist approach to managing the hyperacute phase of stroke. If an ambulance is contacted within two hours of a patient’s symptoms developing a well-practised protocol is followed. Following a call from paramedics, regardless of the time of day or day of the week, computed tomography (CT) scanner staff, laboratory staff, the nursing team and stroke neurologist are contacted and prepare to meet the patient. The patient is met in the corridor of the emergency department by the stroke team and taken directly for a CT scan.

While the paramedic hands over the medical history, medication and symptom summary to the neurologist, the patient has blood taken by two members of staff: one takes blood for the laboratory; the other takes a finger prick sample for coagulation levels. The results are available in two minutes.

This rapid approach means that patients receive thrombolysis on average within nine minutes of arrival at the hospital. The national target for thrombolysis in the UK is one hour.

Last year 16 per cent of patients at the University Meilahti Hospital in Helsinki received thrombolysis. As a result morbidity rates for patients who have had a stroke and have received thrombolysis have improved considerably (Wahlgren et al 2007).

Controversy
One aspect of the stroke pathway in Finland that is controversial is that thrombolysis is only licensed for adults under 80 years of age, or those defined as in a ‘good pre-morbid state’. The evidence for these parameters is relatively weak and international trials are being undertaken to examine this further (Sandercock et al 2008).

In the UK all patients with suspected stroke, regardless of age and condition, are admitted to the local acute hospital for full treatment, which may include thrombolysis. It appeared to us that in Finland the paramedics make the initial assessment and decision about whether to transfer patients to the university hospital for thrombolysis. Patients who are not considered to fit the criteria are taken to the local city hospitals which offer less interventionist treatment.

There is considerable evidence to suggest that while medication is important for reducing stroke disability, management on a stroke unit is even more beneficial and can have positive effects (Langhorne and Dennis 1998).

Voluntary sector
The second aim of our visit was to look at the voluntary sector. The Stroke and Dysphasia Federation (SDF), the Finnish equivalent of the Stroke Association, has a strong stroke club element, similar to the UK.

However, it also offers two unique services – interpreters and residential courses. The interpreter service is funded by the Finnish government, and the interpreters, who are trained speech and language therapists, act as advocates for people affected by aphasia. The interpreters enhance people’s independence by, for example, accompanying them to doctors’ appointments, and their overall aim is to support people to live at home.

In addition the SDF has residential courses, financed by the local authority, that offer people with speech problems and their partners up to ten days at a specialist centre to learn how to ‘live’ after stroke. The free courses involve intensive group communication sessions and there is a strong emphasis on independence and how families can support each other.

General differences
Although our trip was focused on stroke management, it was fascinating to see some of the other differences between our two healthcare services. The nurse staffing levels are similar to the UK, but the roles vary considerably. For example, the nurses have a strong therapeutic input into patient care, and many are trained in the Bobath concept, a rehabilitative strategy for people with brain injury (Bobath 1993).

The nurses are also interventionist during the hyperacute phase of patients’ illnesses and can ventilate patients on general wards if needed.

The approach to infection control is interesting. meticillin-resistant Staphylococcus aureus is not considered to be a problem in Finland and this is perhaps because as soon as patients arrive in emergency departments all their clothes are removed, sealed in a large plastic bag, stored in the depths of the hospital and returned on the day they leave. Patients wear gowns for the duration of
their admission or, if they are in the rehabilitation hospital, they wear hospital-issue tracksuit trousers and jumpers.

Medicine administration is another major difference we noticed. Nurses in the UK can spend hours doing drug rounds, however the Finnish system is radically different.

The night shift nurse dispenses the full 24 hours’ worth of drugs and puts them in different colour pots for different times of the day. The day nurses then hand out the appropriately coloured pot to the patients. Even more interesting is that the nurses do not have to sign the drug chart. This method of drug dispensing would free up a significant amount of time, but is unlikely to be adopted in the UK.

A vital part of the trip was considering what aspects of good practice we might be able to implement locally. On our return we produced a series of low, medium and high cost recommendations, some are listed in Box 1. We have had a positive response, locally and regionally, but implementation has been slow.

Lessons learnt
Visiting a different country has given us a chance to gain a better understanding of how other health providers work and has enabled us to look at the services we provide in our own locality. As busy professionals we often lack the time to evaluate the systems and processes we are involved in day to day. But this trip created an opportunity for us to recognise what we do well and to think about areas that could be further developed.

The most important aspect of the trip is discussing with colleagues, through meetings or formal presentations, the possible implementation of some of the good practice we witnessed in Finland. If we can use Finland’s ten-year experience of prompt thrombolysis, and 40-year experience of voluntary aphasia support services, to influence care in the UK, we can further enhance the excellent services we offer people who experience this devastating and life-changing event.

Implications for practice
- Visits to units abroad can inform nursing practice by enabling different ways of working to be experienced. This can enhance nurses’ knowledge and enable them to reflect on practice.
- Visits to units abroad can also develop regional, national or international collaboration.
- Nurses could consider visiting another unit in their country or abroad.

Box 1 Some recommendations for the south west region following the Finland trip

**Low cost**
- Development of a clear, consistent protocol for hyperacute management of stroke involving input from all key staff.
- Ambulance staff should be able to telephone ahead to alert the thrombolysis service. The radiology department should also be alerted so that a scanner is prepared for the patient’s arrival.
- A portable international normalised ratio recorder should be kept in resuscitation areas of emergency departments so that a blood result can be available in two minutes.
- Stroke teams should be expanded to include a phlebotomist.

**Medium cost**
- General first-aid training for adults should include immediate stroke management, although the Department of Health’s recent FAST campaign might heighten the public’s awareness of stroke.
- Nurses and physiotherapists should be trained in swallowing assessments.
- An interpreter service for people with aphasia should be developed.

**High cost**
- A residential course for people who have had a stroke, and their partners, should be developed. The service could operate from educational establishments outside of term time.
- A pilot would be required as well as feasibility studies regarding venues, costs and tutors/trainers.

References


