The stroke rehabilitation ward for men through the accident and emergency after a...

Life

Introduction

This essay will discuss continuing care of a male elderly patient who was admitted into the stroke rehabilitation ward for men through the accident and emergency after a fall at home. It will also describe and analyse his care needs and how it will be carried out laying emphasis on mobility as a specific need. Patients are admitted from other wards or accident and emergency but mainly from the acute elderly care wards, then transferred to the stroke rehabilitation ward for specialised care until they are discharged to their homes, or to a residential ornursinghome. The conditions of each patient when admitted varies with individual, some might have severe cerebrovascular accident (CVA) or falls and confusion at home or other related cases.

This essay is about a 72 year old Asian male whom I would refer to as " Musa" for the sake of confidentiality, who was admitted into the accident and emergency after being found on the floor of his bathroom by his wife who then called the ambulance. He was diagnosed with a left sided stroke which caused paralysis of the entire right side of his body, and was also diagnosed of irregular heart rhythm which is a probable cause of cerebral ischemia which means blood clot of an artery that prevents enough oxygen rich blood from getting into the brain then causes the brain cells to die. To prevent further clotting of the blood he was placed on wafarin an anticoagulant, his past medical history stated that he suffered from osteoarthritis, and was prescribed pain killers.

Musa was brought into the stroke rehabilitation ward by a porter, accompanied by his wife and daughter, this ward is mainly for rehabilitation which is the process of assisting an individual to maintain a high level of function, independence and quality of life in their home or in the residential homes. He was taken to his bedside, after he had settled, a staff nurse went to him , the staff nurse introduced herself then sat down with them to start an admission process with the trust’s admissions pack (Walsh et al 2001), due to insufficient information about him she read through his transfer notes and continuation sheets from the accident and emergency where he spent approximately a day the information gotten were not conclusive, so we had to check his blood pressure, it was 120/80 mmHg, his temperature was 65. 5, his pulse rate was 120 and saturation was 70% the staff nurse had to give him oxygen of 4 litres through a facial mask.

The admission pack contains relevant information needed to assess, plan and evaluate a standard of care that will meet all clinical governance standard and this package of care is based on Roger, Loper and Tierney’s activities of daily living (Roper et al 1996). These documentation and assessments, forms an integrated care pathway which the multidisciplinary team uses to check a patients progress over a certain period of time. The ICP also empowers patients and aids effectivecommunicationof information within the multidisciplinary team, in order to carry out proper interventions required for a patient and making sure it meets the required standard of clinical guidance (Middleton et al 2001).

Once the assessment document was completed, it was discovered that so many care plans would be needed to correctly meet his needs, , he has got slight dysphasia and unable to communicate properly which a few stroke victims do suffer from (Alexander et al 2001) but no hearing problems was noted. He was asked questions that needed short answers to aid his ability to express his feelings rather than relying on afamilymember, after this assessment he was referred to the speech and language therapy (SALT) who carried out strategies which included vocal exercises. It was also discovered that his mobility was very poor due to paralysis on his left side taking into account hazards, and a fall was one of the causes of his recent admission into hospital.

When I started my placement on the ward he had already been admitted for 3 weeks and Musa was on fluid intake via intravenous infusion to maintain arterial blood pressure and the staff nurse in charge of his care maintained this intake at the correct rate. The malnutrition Universal Screening Tool (MUST) was used on admission and he scored 2 which is a high risk, the medical team was informed and afoodrecord chart for 5 days was commenced and his weight was recorded and to be checked twice a week (Nutritional benchmarking group 2008). According to his records he is unable to chew food, and has been having difficulties swallowing, he was then referred to the dietician who assessed him and placed him on a stage 2 diet which is a liquidised meal, this type of food promotes a swallow reflex action because it has been thickened with thickener as un-thickened food can run down the throat too quickly for the trachea to manage, and sometimes patients gets choked.

Mobility was a main care need identified, Musa is incontinent with faeces and urine he has got a catheter and a pad which needs frequent changing he is unaware that he has already been, since he has got no control over his elimination, there was a fluid balance chart to record any abnormalities and stool chart to determine and establish a pattern of his bowel movement which was used to aid his comfort. Due to his poor mobility, he might develop skin problems leading to pressure sores. In the falls risk assessment form in his folder, he is classed as high risk, his bed is in an observable area, his bed is kept at a very low position and re-positioning at each intervals.

Musa’s notes stated that there was a multidisciplinary team meeting (MDT) held at the first week of his admission and the occupational therapist comes to the ward every other day to see him and when he is having a wash she tells the nurse to encourage him have a grip of the sponge in his right hand and with the help of the nurse’s hand would gently stroke the other arm to regain muscle memory and the use of the paralysed arm. The physiotherapist comes in to see him once a day and to encourage him to sit on his bed for a couple of minutes then increased it gradually from five to ten minutes then to twenty minutes and then to half an hour, by the end of 5 weeks he was assisted into a specialised stroke chair with side supports. This team meets every week to discuss Mr Musa’s progress, it is in accordance with the new government guidelines on white paper “ Saving Lives: Our healthier Nation” It lays emphasis on the values of cross departmental working in partnership and as a team within the local, healthauthorities, private sectors and voluntary sectors (DOH 1999).

Musa’s wife and all relevant personnel were present and discussions on how he has progressed or declined and what other care needs were identified or if there were any changes to be made to improve his recovery. The Physiotherapist suggested twice a day visit would be of advantage instead of once, an additional note was added to his care plans about that. With his family fully involved there was no signs ofdepressionshown physically although the Geriatric depression scale was not used . With gradual changes to his care plans and subsequent meetings, the team felt he was fit to be discharged home and continue with the community stroke rehabilitation and a social worker was invited to the last meeting to arrange the possibilities of care within the community according to the patient’s wishes.

Reflecting on this outcome it became a success seeing that the necessary assessments were carried out in the right ward (the rehabilitation ward) appropriately with the right documentation, and in accordance with the guidelines stipulated by department of health and the nursing models used also contributed to the positive outcome and quick result. In conclusion the relevant health professionals were involved in the continuity of Musa’s care, with his family and his wishes put into consideration.

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