

Summative
assignment:
discursive essay
cerebrovascular
accident (cva) and
mobilit...

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Introduction

This essay will explore a 'needs orientated' approach to the care of CVA patients and examines the importance of using models and frameworks within nursing practice. National and global statistics of CVA will be discussed. Using a case scenario, the needs of the patient will be explored and nursing interventions discussed with respect to dignity. The social, biological and psychological impact of mobility problems of CVA patients with reference to the scenario patient and other patients seen during nursing placement will be investigated. A holistic plan of care will be critiqued with respect to nursing models and frameworks utilised by NHS, underlining the importance of individualised care plans.

The patient scenario is of a retired gentleman (William) of 70 years, previously diagnosed with hypertension, obesity and a BMI of 5. Recent GP consultation reported tiredness, headaches and dizziness, with persistent high BP despite medication changes. William was found by his wife suffering with facial weakness, asymmetry, slurred speech and an inability to raise arm or leg on the right-hand side. He was diagnosed with left-sided CVA and has right-sided, affecting balance and co-ordination, total incontinence, memory loss, dysphagia and difficulty with mastication. Psychologically, he has emotional lability and appears anxious and depressed. He is dependant for daily activities of living (AL's) and forgetful of his condition.

CVA occurs when blood flow is absent in the brain for longer than a few seconds, resulting in cell death and permanent damage. The pathological background may be ischemic or hemorrhagic disturbances of the cerebral

blood circulation.

Ischemic stroke is caused by blockages in blood vessels that supply the brain. These may be due to plaques on the arterial walls caused by fat, cholesterol and other plaque-forming substances. This may happen in two ways:

1. Thrombotic stroke occurs when a clot forms in a narrowed artery.
2. Cerebral embolism or embolic stroke occurs when a clot is transported into the cerebral circulation, causing localised cerebral infarct.

Hemorrhagic strokes are caused by blood leaking into the brain due to damage blood vessels in brain rupturing, conditions such as hypertension, arteriovenous malformations or bleeding disorders can the increase risk (McCance, 1997).

Left-hemisphere (LH) stroke is characterised by loss of movement control on the right side of the body. The LH of the brain controls speech and language abilities, which may lead to aphasia, manifesting in a wide range of difficulties including inability to control speech related muscles or the ability to write, read or understanding language. LH stroke victims often develop a cautious behavioural style. Frequent instruction and feedback to complete tasks may be necessary. Development of memory problems is common to all CVA patients and can manifest as shortened retention p, failure to understand and absorb new information or difficulty in generalising and conceptualising (McCance, 1997).

The essay will focus on the motor difficulties that William faces due to right-sided hemiplegia, the resulting complications and concomitant reduction in AL's. Mobility is a key issue with CVA patients and affects most aspects of

life. In William's case, due to his forgetfulness he attempts to stand unaided, increase risk of further injury. CVA occurs suddenly, affecting all aspects of living, resulting in a loss of independence and bringing unexpected and unwanted changes. The main result is often a loss of freedom within one's own body resulting in feelings of vulnerability, helplessness, fear and loss, as well as the loss of dignity caused by feelings of inability to manage even the simplest of tasks independently.

Main

CVA

The WorldHealthOrganisation (WHO) defines CVA as clinical signs of focal (or sometimes global) cerebral impairment (WHO, 2006). These may develop rapidly and continue for 24 hours+ or lead to morbidity without distinguishable reason other than vascular source (Aho et al., 1980). The consequences of CVA are often complex and heterogeneous depending on etiology, localisation and severity. In the UK, CVA is the 3rd frequent cause of death with approximately 24% of patients dying within 4 weeks of onset (Wolfe, 2000) and globally it is the 2nd leading cause of death (WHO, 2006). In the UK, incidence of CVA is around 150, 000 per annum (National Audit Office, Department of Health. 2005) and it consumes around 5% of health service resources (Langhorne, 2009). CVA incidents are a major cause of complex adult disability and up to 300, 000 individuals adjust their life around moderate to severe disability (Adamson et al. 2004). Epidemiological studies have shown that approximately 52% of survivors return home with lasting disability (Wolfe 2000) although 30-40% will remain dependent in AL's (Dobkin, 1995).

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Cause of CVA

CVA is a multi-factorial disease with many determinants categorised as changeable or non-changeable. Risk factors such as age and sex are non-changeable and in many populations, older males are associated with an increased susceptibility (WHO, 2006). In contrast, reduced exposure to changeable factors can reduce CVA risk. These factors include smoking, physical activity, diet, or environmental aspects such as passive smoking (McCance, 1997). These combined risk factors, which do not all have to be present, will over time influence the subject's possibility of suffering CVA. In the case scenario of William, his lifestyle contained a number of risk factors both changeable and non-changeable, e. g. gender and poor diet leading to hypercholesterolemia.

According to WHO, diagnosis of CVA includes one or more of these focal signs (WHO, 2006):

- Unilateral or bilateral motor impairment including un-coordination
- Unilateral or bilateral sensory impairment
- Aphasia/dysphasia
- Hemianopia
- Diplopia
- Forced gaze
- Acute onset apraxia
- Acute onset ataxia
- Acute onset perception deficit

Biopsychosocial care and the impact of CVA

Understanding the impact of a health-state on a person requires measuring

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that person's performance of tasks and actions in their normal environment (WHO, 2006). The biopsychosocial approach to health focuses on person-centred care, where patient involvement in clinical decision-making and self-management are key factors (Fayers P, 2007). CVA recovery is not predictable, and while improvement from initial symptoms predominantly occurs, there is tremendous variability in the degree of progress a patient may make. Some will return to normal while others make only moderate improvement, and a few have little or no recovery. Generally, the first 6 months sees the greatest recuperation after the stroke, although recovery can occur for up to 2 years.

The biopsychosocial consequence of CVA can be overwhelming; for both the patient and for their family, resulting in a great strain to family life. CVA can change the family power dynamic: the sufferer becomes more dependent, requiring greater emotional support as well as physical help. These strains can lead to a divorce, the spouses of CVA survivors report a lower fulfilment in quality of life (Ostwald, 2008). CVA's unpredictable recovery process can result in victims living a fraction of their previous life. A long-term CVA survivors survey found that 87% had ongoing motor problems, 54% suffered walking difficulties, 52% reported hand movement/coordination problems and 58% experienced spasticity (Jones, 2006). These high figures demonstrate how life after CVA can radically change all aspects of living. A biopsychosocial model for sufferers of CVA is appropriate because post-stroke stressors, e. g. degree of handicap, are unique to each patient and this model can allow for these variations within the care regime (Aben et al.,

2006). This model can also be used to predict long-term rehabilitation participation in CVA patients (Desrosiers et al., 2006).

Dignity and the wider impact on nursing

Dignity is defined as ' a state, quality or manner worthy of esteem or respect; and by extension self-respect'. Within the healthcare setting, dignity has become a major concern in UK health policy, especially in regard to vulnerable or older people (Gallagher, 2008). The National Health Service (NHS) Patient Charter for Scotland (NHS, 1991) states that patient dignity should be respected. A Royal Commission report on long-term care of the elderly stated " the dignity of those who have or who may come to have the need of long-term care should be recognised" , (NHS, 2005). In 2000, the NHS Plan (NHS, 2000) made emphasis to maintenance of patient dignity and the International Code of Conduct of Nursing (ICN, 1973) states that: " Inherent in nursing is respect for life, dignity and the rights of man, which is unhampered by concerns of nationality, race, creed, and colour, age, sex, politics or social status".

Dignity is recognition of the intrinsic value of people, regardless of circumstances, by respecting their uniqueness (Aspinall, 1995). Nurses can make patients within their care feel dignified and valued by having an attentive presence during communication which makes it explicit that the patient is unique and esteemed and their opinions are being taken into account; feelings of worth are central to dignity and important to health and quality of life (Thomas and Quinn, 2002). Nurses should encourage patients to attempt AL's and aid where needed, rather than forcing the patient to be ' cared for'(Mains, 1994, McCartney, 1974, Silverman). Communication and

cognitive problems in CVA survivors can result in patient opinions being misinterpreted or overlooked and decisions can be made on their behalf without adequate consultation. Therefore it is important to ensure patient wishes are adhered to and where necessary, to involve Speech and language (SLT) and Occupational therapy (OT) to provide supportive communication methods, thus respecting patient dignity (Silverman).

Caring for the CVA Patient

Despite advances in CVA prevention with better acute care and greater emphasis on rehabilitation, prognosis after acute CVA remains poor with 20-30% of patients dying within a month and 13% being discharged to institutional care (Rodgers, 2008). Multi-disciplinary teams are recognised as best practice care in CVA management, and each discipline takes a unique role in the recovery process, e. g. physiotherapy interventions focus primarily on interactions between body function and motion by strengthening weakened muscle and increasing flexibility. SLT is involved in the recovery of communication and swallowing, and can provide supportive communications methods. Dieticians help in nutritional management for over or underweight CVA patients and in conjunction with SLT, the correct food consistencies required for individuals with dysphagia. OT focuses on independence and function, setting individual goals using task adaptation and environmental modification to underpin action and activity of the patient (Rowland T. J., 2008). Nursing interventions are often characterised by caring for basic needs and sustaining personal and social integrity (McCartney, 1974), which is vital in ensuring the correct professionals in a stroke rehabilitation team are informed of the day to day changes in the patient

(Hartigan, 2011). Therefore nursing professionals should have a thorough understanding of what each profession can contribute to patient rehabilitation.

In accord with NHS stroke models (NHS, 2010), care and rehabilitation should aim to re-establish and maintain functioning, promote health, and prevent and minimise disability (Stucki G, 2002). Essentially, rehabilitation should optimise participation in life and empower the CVA sufferer. The manifold and chronic consequences of CVA necessitate the combined efforts of different disciplines to fulfil rehabilitation objectives (NHS, 2010). For this reason, specialised multidisciplinary teams are characteristic of stroke units, providing the most beneficial outcome globally (Seenan P, 2007).

Nursing plan of care

Clinical stroke guideline CG68 as set out by the National Institute for Health and Clinical Excellence (NICE), recommends that 'all people with suspected CVA should be admitted directly to a specialist acute stroke unit following initial assessment'. Studies have shown that inter-professional, patient-centred care and rehabilitation optimises participation in life (Stucki G, 2002). A care plan for William has been made detailing the nursing APIE, the main details have been summarised in table 1.

The care strategy for William considers not just the CVA but also his pre-existing conditions. William suffered with hypertension which would require monitoring to warn of risk of further CVA incidence (Ahmed, 2010). This would be performed by taking BP readings regularly and notifying appropriately if the BP readings were sufficiently elevated to denote risk.

William is obese with a high BMI, and at present he is suffering from feeding difficulties as the CVA has caused dysphagia, a difficulty in swallowing and mastication caused by the right-side hemiplegia. Discussion with dieticians would ensure he has the best diet for his condition presently. Dysphagia can introduce a number of risk factors, e. g. choking or food lodging in the airways, which could cause chest infection. SLT should assess William's swallow reflex and discuss whether he requires a nasogastric tube for nutrition. NICE 2010 Quality Standard 4 for Stroke states. " Patients with acute stroke have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they have an ongoing management plan for the provision of adequate nutrition" (NICE, 2010). If he be capable of swallowing without risk, a soft food diet could be given initially, with solid food being introduced gradually with encouragement to self-feed as much as possible. This would help increase dexterity and upper limb function, although private meals will reduce loss of dignity in the early period (Bernhardt et al., 2004, Mains, 1994).

William has double incontinence due to the CVA. CVA suffers frequently become urinary incontinent which can cause considerable distress (Brittain, 1998), faecal incontinence more so. Nurses need to manage this problem respectfully, furthermore, they should appreciate embarrassment over incontinence can adversely affect the rehabilitation progress (Chipps, 2011). Therefore it is important to retain patient dignity during occurrence of incontinence and reassure that muscle controlled can be regained with training. There are a number of behavioural strategies that can help the

sufferer, for example, helping William to sit on the toilet just after a meal (Silverman). NICE 2010 Quality Standard 8 for Stroke states: “ Patients with stroke who have continued loss of bladder control two weeks after diagnosis are reassessed to identify the cause of incontinence, and have an ongoing treatment plan involving both patients and carers” (NICE, 2010). Initially, William will be wearing incontinence pads and so peritoneal skin examinations are needed to ensure tissue viability. Incontinence is a by-product of stroke and is often viewed poorly by family of the CVA survivor. It is vital to emphasise to the family that this condition is extremely common following stroke and that this problem is not controllable by William (Brittain, 1998).

William will require physiotherapy for the hemiplegia to increase strength and muscle tone, which is necessary full limb mobility recovery. The most common physical effect of stroke is muscle weakness and reduced control of the affected arm and/or leg. Research has show that on average patients daily spend 28% of the time sitting out of bed and only 13% engaged in activities based on movement (Bernhardt et al., 2004), sitting without activity will not aid towards increasing mobility, therefore it is imperative to schedule and encourage activity. Activities can be devised in conjunction with OT supplying walking aids and other environmental adaptations to aid with early mobility and independence of AL's. NICE 2010 Quality, Standards Standard 7 states: “ Patients with stroke are offered a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week, at a level that enables the patient to meet their rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to

tolerate it”(NICE, 2010).

William is confused and suffering from memory loss, he is depressed and anxious about the future, while this is common to stroke sufferers, these emotions should be treated with understanding and sympathy, and nursing staff should be watchful for signs of acutedepression(Pelissier, 2008). NICE 2010 Quality, Standards Standard 9 states: “ All patients after stroke are screened within 6 weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment” (NICE, 2010). Most stroke victims experience a grieving process at the loss of their old life, until they reach an acceptance of who they are after the stroke.

Even when William is discharged from hospital there are standards that will ensure high quality community care for him and his family (Siegler et al., 2006, Wolfe et al., 2000). NICE Quality Standard 10 states: “ All patients discharged from hospital who have residual stroke-related problems are followed-up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management.” (NICE, 2010) and Quality Standard 11 states: “ Carers of patients with stroke have: a named contact for stroke information; written information about patient’s diagnosis and management plan; and sufficient practical training to enable them to provide care” (NICE, 2010)

Mobility and the biopsychosocial impact

Mobility has been identified as a vital functional ability which determines the degree of independence and thus health care needs especially among older people, and the greatest impact of impaired mobility is the effect on self-concept and self-esteem (Hogue, 1984). CVA patients often state that they

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feel 'fearful and helpless' and want to 'regain control of their lives' (McKevitt et al., 2000). Benchmarks associated with physical functioning evaluate progress and CVA survivors often relate their improvement using activities that have a wider social meaning (Hartigan, 2011). Often the limb is blamed for the difficulties (Hartigan, 2011), during placement one older gentleman would thump his leg and call it useless, transferring all his mobility problems onto the affected limb. Patient perception of their health influences rehabilitation, reinforcing the need for biopsychosocial models of health, as this demonstrates the interrelated nature of physical and social activities, also emotional well-being facilitates recovery from CVA (Dowswell, 2000). On placement, a gentleman spoke about his plans to play golf again when he could stand unaided. Often patients do not express personal goals to medical personnel but nurses can convey this information to the stroke team ensuring patient focussed recovery goals (Hartigan, 2011). Nurses can help with the bereavement process that most stroke victims will suffer at the loss of their pre-stroke life, monitoring patient perception of recovery and aiding in education of stroke to ensure they have a positive and realistic view of their post-stroke life to allow patients to retain dignity throughout rehabilitation (Christensen et al., 1997, Mangset et al., 2008, McKevitt et al., 2000).

Conclusion

The global burden of CVA is increasing with frequent lasting disability, but holistic care plans and biopsychosocial models may reduce rehabilitation time and retain dignity of the patient by being involved in their recovery.

CVA is a sudden crisis; patients are often fearful of the future and left feeling

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trapped within a non-responsive body. Nursing staff are in a unique position to aid with mobility and continence by encouragement; to discuss with patients about their personal goals for recovery and pass this information to the stroke team allowing patient-orientated goals to be devised; and to aiding in the bereavement process CVA victims suffer. For a few, mobility will never fully return but with changes to the environment around them, they can retain some independence and return to a meaningful life.

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