Stroke Update March 2013

Community Stroke Rehabilitation and Early Supported Discharge

The Rehab team continues to work closely with the Enablement Team to manage people in the community enabling them to rehabilitate in their own environment and remain at home. The team also undertakes the six week reviews post discharge home for all stroke patients.

The team supported 66 new referrals for rehabilitation and 10 ESD direct from HASU in **quarter 2**; in **quarter 3** they have supported 66 rehabilitation patients and 12 ESD direct from HASU. 54 six weeks review was completed in **quarter 3**. **Quarter 4** data is yet to be finalised.

92% of patients said they had improved after input from the team in quarter 3

Stroke Navigator:

The Stroke Navigator supports stroke survivors, their families and carers to navigate health and social care systems in Enfield. The navigator continues to work closely with the community rehab team and other voluntary sector services such as Attend, Stroke Action and Ruth Winston Centre to encourage those affected by stroke to re-engage with their community and access life after stroke.

The navigator supports stroke patients, their families and carers in their discharge home process and as such undertakes a discharge home experience questionnaire within ten days of the patient being discharged home. **In the 3rd and 4th quarter** 77 stroke patients completed the discharge home questionnaire, 70/77 rated their overall journey as good, very good or excellent. Feedback/issues arising from the discharge home experience questionnaire were feedback to the relevant trusts. Representatives from both North Middlesex Hospital and Barnet and Chase Farm hospital attend the monthly stroke pathway monitoring meeting where these findings are discussed. The feedback process has led to an improvement in patients' experiences.

The navigator provides six weeks review (Non CSRT) to stroke patients. This cohort of patients are either those that leave the HASU and are so high functioning need no community involvement or patients who are at the other end of the spectrum and not referred to CSRT as no perceived rehab gains possible. **In the 3rd and 4th quarter**– 10 stroke patients received the six weeks review.

Life Role Facilitator:

The Life Role Facilitator facilitates stroke survivors to re-integrate back into the community through taking up volunteering opportunities. She also undertakes the six month reviews for all stroke survivors. In **quarter 3** 36 patients received the six months review, 7 patients returned back to work and 5 took up volunteering roles; in **quarter 4** 28 received the six months reviewed, 9 returned back to work and 3 took up volunteering roles.

Social Support
The service provides community based social support network for stroke survivors, including awareness and secondary prevention. In **quarter 3** 25 referrals were made to the team, awaiting data for **quarter 4**

The carer forum which was set up by the social support team is doing very and they are working very closely with the Enfield Carers Centre, the forum is held quarterly

Befriending Scheme at North Middlesex Hospital
The befriending scheme at North Middlesex Hospital is now up and and has taken off really well. There are 4 befrienders who are all stroke survivors, each of them are assigned to a patient or group of patients on the stroke unit and they assist with activities that support communication, understanding of living with stroke and patient experience.