The medical nurse practitioner’s role in early stroke recognition

STROKE is common and has a major impact on people’s lives (Davenport et al, 1995). It is one of the world’s major health care problems, being the third leading cause of death and main cause of disability in industrialised countries (Lott et al, 1999; Bonita, 1992). Stroke begins as an acute medical emergency and presents complex care issues for the health care professional. For patients, it can lead to hospital admission for long-term care.

Assessment – a crucial time

Patients suffering from an acute stroke, who are admitted to hospital, are usually assessed by a junior doctor (Davenport et al, 1995). During this initial stage, it is essential that an adequate clinical assessment is carried out promptly. The assessment should include an accurate history from either the patient or relative, coupled with a detailed examination of the patient. The information gained is used to reach a correct diagnosis, help predict the patient’s outcome and plan the management of the patient’s care (Davenport et al, 1995).

The outcome for people who are diagnosed with having a stroke is greatly improved if an appropriate and prompt admission can be arranged into a hospital-based stroke unit, with treatment and care provided by a specialist stroke team. However, there is only minimal evidence of appropriate and timely admission into hospital-based stroke beds (Department of Health, 2001).

Stroke has been recognised as a common medical emergency and strategies for treating acute stroke are continually evolving (Hennerici, 1999).

Stroke is the most common neurological emergency that junior medics and nurses in A&E are likely to witness. Recent research suggests that it may be possible to reduce mortality and improve functional outcome in the management of stroke, provided that clinicians act appropriately, and more quickly, with diagnostics and therapies for the patient who has had a stroke (Hennerici, 1999).

Specialised stroke services

According to the National Clinical Guidelines for Stroke, published by the Royal College of Physicians (2000), every organisation involved in the care and treatment of patients who have had a stroke has a responsibility to ensure that they are cared for by services specialising in stroke and rehabilitation. The guidelines recommend that these stroke services should comprise an identified stroke unit with a dedicated multidisciplinary team of specialist staff, working within agreed protocols and providing educational programmes for other staff, patients and their carers.

The development of protocols and systems for the assessment and treatment of patients with acute medical conditions is one of the main purposes of a medical nurse practitioner in the A&E department. In our A&E department in a large teaching hospital in the Midlands, the assessment stage of this process is slowly becoming part of the role of the medical nurse practitioner. The nurse uses a clinical assessment proforma to ensure complete and accurate recording of patients’ details. It is hoped that the medical nurse practitioner’s intervention at the assessment stage for patients who have been admitted with a stroke will provide a more timely and appropriate referral and direct access stroke beds.

The prognosis of a patient who has had a stroke greatly depends upon appropriate and timely management. Hennerici (1999) supports this view, stating that the patient should ideally be in a specialised stroke care unit with a specialised multidisciplinary team. As already established, specialist nurses have an important role to play within such dedicated stroke units, but they can also improve the quality of care received by patients on discharge. Forster and Young (1996) conducted a quantitative study to investigate the difficulties encountered by patients who have had a stroke, including a lack of community services on discharge from hospital. As part of the study, they evaluated whether home visits from specialist nurses would enhance the social integration and perceived health of patients who have had a stroke and alleviate stress for their carers. It was found that specialist nurses’ visits had a small effect on improving social activities for mildly disabled patients.

Prevention is better than a cure

Bonita (1992) warned that unless a decline in stroke incidence can be achieved, the numbers of people who have had a stroke would rise significantly as the age of the population increases. The most costly part of the care of a patient who has had stroke is hospital care in the acute phase (Bonita, 1992). Actions to reduce the risk factors for stroke in the population are addressed in many government publications.

The NHS Plan (DoH, 2000) sets out the main national priorities to provide patients with fair access to services and high standards of care. These standards for key conditions and diseases (including stroke) are set out within the national service frameworks (NSFs).

Standard 5 of the National Service Framework for Older People (DoH, 2001) states that the aim is to reduce the incidence of stroke in the population and to ensure that those patients who have had a stroke have prompt...
A magnetic resonance imaging (MRI) scan with angiography showing the internal bleeding due to a stroke (in orange). The left side of the brain is affected, so paralysis will occur in the right half of the body. The brain is viewed from the front.

In the last decade, the political agenda has greatly impacted on the development of new nursing roles, as there have been many changes in the delivery of health care within the NHS. The government has set initiatives within documents such as A First Class Service: Quality in the New NHS (DoH, 1998), which drive the modernisation of the NHS. This ethos of providing a quality service has been reinforced through the emergence of clinical governance (DoH, 1999).

Horrocks et al (2002) concluded that nurse practitioners provide the same level of patient satisfaction and similar health outcomes as do doctors. However, further study in this area is called for to provide research to confirm that the assessment from a nurse practitioner is safe and competent and that the role of a nurse practitioner is more clearly defined in practice (Horrocks et al, 2002; Armstrong, 1999).

The development of a stroke pathway

As already established, one of the main purposes of a medical nurse practitioner within the A&E environment is to develop protocols and systems for the assessment and treatment of patients with acute medical conditions within the A&E department. Crucial to the effectiveness of this role is the facilitation of an improvement in the quality of health care outcomes for patients presenting in A&E with acute medical conditions.

In September 2001 the new role of medical nurse practitioner started within our busy A&E department. The development of a stroke pathway through A&E is one of the first major projects we have embarked upon, in relation to developing protocols and systems to ensure a smoother transition for the patient from A&E to the appropriate ward or discharge destination (Fig 1).

In conjunction with the multidisciplinary team for stroke care within this trust and Dr Chelsea Kidwell of the UCLA Stroke Centre in Los Angeles, California, we have developed a protocol to assess, evaluate and fast track medical patients receive and contribute towards deflecting medical admissions.

In a systematic review to determine whether nurse practitioners can provide care at the first point of contact equivalent to doctors in a primary care setting, Horrocks et al (2002) found that nurse practitioners can provide a quality of care to patients that is comparable with the quality of care provided by a doctor. However, they acknowledge that there is much ambiguity over the term ‘nurse practitioner’, with substantial overlap between other nursing roles including that of ‘nurse consultant’ and ‘clinical nurse specialist’ (Horrocks et al, 2002).

Armstrong (1999), suggests that specialist nursing roles have a specific impact on the outcome of the patient, playing a major role in patient education, reducing the length of hospital stay and ultimately preventing admission into hospital.

A&E nursing is one area where nurses are expanding and developing their roles as independent practitioners. Emergency nurse practitioner roles are being developed throughout the country so that minor injuries can be treated without needing to refer to a doctor (Autar, 1996). The success of a nurse-led fracture review clinic for minor injuries has been shown to provide quality care and a timely service Wardman (2002).

In our large teaching hospital in the Midlands, two medical nurse practitioners have been employed within an A&E department to help improve the nursing care medical patients receive and contribute towards deflecting medical admissions.

References


access to stroke services. According to The NHS Plan (DoH, 2000), the immediate care management of the stroke patient means treatment by specialist stroke teams within designated stroke units.

The outcome for patients with suspected stroke is dependent on many factors, including making an accurate diagnosis, provision of treatment in line with the agreed national clinical guidelines and wider multidisciplinary assessments, all of which are better managed and provided within a specialised stroke unit.

The intervention by the medical nurse practitioner in the A&E department aims to improve the outcome for patients with suspected stroke by providing them and their families/carers with relevant, useful information, and ultimately facilitating a more timely and appropriate method of referral to a specialist stroke unit.

Health care delivery and nursing roles

During the last decade fundamental changes have occurred in health care delivery. These changes have called for role developments within the nature and expertise of levels of clinical nursing practice (Carroll, 2002). The concept of a nurse as a specialist practitioner has been widely documented over many years and is not new (Carroll, 2002; Miller 1995).

The Scope of Professional Practice (UKCC, 1992) offered new opportunities for nurses, midwives and health visitors to develop their clinical roles. This has enabled them to expand and extend their practice in order to meet the changing demands of patients, respond to service developments and policy implementation, and enhance and extend services throughout the NHS (Waller, 1998).

According to Walsh (2001), the principles of accountability and professional autonomy encompassed within the UKCC document, together with the fundamental changes in health care delivery during the last decade, have made the development of the nurse practitioner necessary and inevitable. The role of the nurse practitioner has since developed dramatically in the UK, coming from the community through the A&E department and into the acute hospital setting (Walsh, 2001).

Defining the role of the nurse practitioner

There is still much confusion and debate over specialist and advanced nursing practice, on which the UKCC and more recently the NMC have offered guidance on advanced practice. Specialist or expert practice must be supported through relevant educational programmes and even to degree level (Carroll, 2002). Hicks and Hennessy (1999) consider educational requirements, supervision and regulation to be the foundation of advanced practice and call for formalisation within our professional bodies to ensure equity. If this doesn’t happen, a further lack of clarity of role definition and a devaluing of the nurse practitioner may result (Hicks and Hennessy, 1999).

The increase in new nursing titles in the last decade can be seen as evidence that there is a lack of control and conceptualisation over emerging roles within the nursing profession. Such roles continue to develop and this could be due to economising and a need to reduce junior doctors’ hours, rather than the development of expert nursing practice.

Scott (1998) warns that the creation of new nursing roles as an attempt only to improve the life of junior doctors, could be seen as an abuse of clinical nursing expertise if adopted piecemeal, and only adds to the continuing identity crisis within nursing. Despite the benefit of new roles in equipping nurses to take the initiative in making changes to ensure that patients are seen quickly and efficiently, Gallagher (2002) suggests that because the system is failing, more initiatives are being put into place and nurses are often asked to do jobs that would have previously been the remit of a junior doctor.

It is essential to have a clear vision for the role of a nurse practitioner, with a firm educational grounding. The role is primarily about improving patient care and has a higher level of accountability and autonomy. Its focus is the undiagnosed health problems of the patient. The nurse practitioner aims to derive and implement a plan of care after an initial assessment (Walsh, 2001).

Emergency nurse practitioner roles

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**References**


