In the Aftermath of Stroke: What is next?

Presenter disclosure information
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FINANCIAL DISCLOSURE:
• No relevant financial relationship exists

Case Presentation
• 72 year old Spanish-speaking South American female presenting with increasing speech difficulties and falls for one day prior to admission
• H/O CVA with residual right-sided weakness and some aphasia, HTN, mild dementia, noted new-onset atrial fibrillation, permanent pacemaker
• Lives in Peru, here on an annual visit with family in the US. Since she had her last stroke she has taken out travel insurance for the trip
• Lived functionally, and meaningfully, with prior CVA
Case background

- Her grandson is a cardiologist, his wife has a law degree but stays home with their three young children.
- They want the best care and outcomes for their mother and will use their resources to give her that opportunity.
- The patient owns the family homestead in Peru.
- It is the family’s hope that she can come home and be cared for by family and be with her grandchildren, but if she had the chance she would like to return to her home in Peru.
- All communication with family and patient done via interpreter phone.
- Only English-speaking family are grandchildren.

Clinical Presentation

- Diagnosed with large left MCA CVA.
- Symptoms include expressive and receptive aphasia, right arm weakness 2/5, right leg weakness 3/5.
- Presented outside the window for IV tPA or endovascular therapy.
- NIHSS 16 on admission.
- Admitted to ICU, intubated for airway protection.
- PT/OT recommend acute rehab vs. STR pending patient progress.
- SLP evaluation deemed patient high risk for aspiration—alternate means of nutrition required.

What are the next steps?

- PEG vs. no PEG?
- Rehab needs?
- Family meeting scheduled, options discussed.
- Family wishes no trach and PEG.
- Proceed to extubation when medically stable.
- Pursue acute rehab when medically stable.
Do we know the Goals of Care?

Goals of Care Process

- Does patient have capacity to direct care? If no, then
- Assess for presence of an advance directive
- Identify health care decision-maker:
  - Is there a legal surrogate designation in the Advance Directive?
    - Health Care Representative
    - Health Care Agent
    - Durable Power of Attorney for Health Care
  - Is there another type of legal surrogate?
    - Conservator of Person
    - Legal Guardian
  - If no advance directive or no designation of a legal surrogate then use next-of-kin hierarchy
    - Spouse
    - Adult Children
    - Parent
    - Siblings

Goals of Care Process

- Clarify patient’s values and preferences for care with legal surrogate or next-of-kin and incorporate written advance directives.
- Discuss prognosis: What is medically possible?
Goals of Care Process

- What do they know? Want to know?
- What do they see ahead?
- Is there an evidence base that is relevant to their situation?
- What can medical care offer, what can’t it offer?
- What’s the (best, worst, likely) prognosis in this pt.?
- How do the burdens & benefits of the proposed care intersect with the patient’s values (is it worth it?)
- Recommend/Negotiate a goal of care (and renegotiate as conditions change.)

Goals of Care Process

- Establish initial goals of care, in conversation with the surrogate, weighing benefits (medical big picture conversation) and burdens (patient perception). Remind healthcare decision-maker that they are the surrogate speaking for and representing patient. (What would the patient want? The aim is to choose as the patient would probably choose, even if it is not what you would choose for yourself.)
**Goals of Care: The Three Paths**
- Restorative
- Conservative medical management
- Aggressive symptom management

**Goals of Care Process**
- Review Code status-Does the code status support the goals of care?
- Communicate plan of care, discussing the interventions appropriate to support goals of care. Communicate what tests, treatments and procedures support the goals of care.
- Review goals of care PRN, in context of time, response to treatment and rehabilitation interventions.

**Restorative:**
Aggressive medical interventions to get the patient back to baseline.
**Conservative Medical Management:**
Treat what is easily treatable and give the patient an opportunity to improve. Limits are placed on the most aggressive interventions ranging from “everything but CPR” to “no escalation of care”.
**Allow a natural death/Aggressive symptom management**
Goals of Care Process

*Consider a palliative care consultation if any step is prolonged, complex or if you anticipate an extra layer of support is indicated.

Case management

* Transitions across care environments require strategic planning to ensure continuity for both the patient and family
* A statement released by the American Stroke Association in 2008, Optimizing Stroke Systems of Care by Enhancing Transitions across Care Environments, highlighted this issue
  * A literature review examining gaps in the current processes
  * Identified areas that need more scrutiny to better prepare for stroke patients’ discharge from acute care to the next phase of their recovery

Case management for stroke

- Initial assessment by case management
  - Collecting information from medical record, reviewing status with staff
  - Identify designated family member
  - Clarify citizenship status?
- What resources are available?
  - Financial i.e. Insurance? Contact information for insurance authorization?
  - Available family members, friends, church, etc.
  - Current living situation
    - How many levels? Full bath on main level? How many live here?
- Collaboration with staff to find ways to help the patient cope and be comforted
  - Communication challenges, pain, elimination, safety, dignity

Recommended for acute rehab, now what??

- Discharge plan after the rehab stay—potential obstacles
  - Patient may not return to prior level of functioning
  - Is the family available and capable to help care for the patient?
  - Is the family forthcoming with asset information
  - Any medical complications?
- With each delay comes the need for reassessment
  - Is the patient still appropriate for acute rehab? Worse? Better?
  - Lost bed?
- Preparing the patient and family for the transfer
  - Frequency of therapy on acute rehab
  - Nutritional needs?
  - New staff, new routine can lead to anxiety
Progression

- Patient was extubated successfully on day #2 and transferred to the stroke unit
- Found to have new onset atrial fibrillation in the workup
  - Patient deemed a significant fall risk, no anticoagulation initiated
- Received PEG on day #4 after family meeting
- Able to participate in 3 hours of daily rehab.
- Accepted on the rehab unit

Transferred to acute rehab on day #6
NIHSS 12

The psychosocial aftermath of stroke

- Every stroke is different
  - As every patient is a unique individual
- But all strokes as they are occurring create:
  - SHOCK
  - FEAR
  - LOSS OF CONTROL

Diagnosis and stabilization

- After initial assessment is complete and progression of symptoms is stabilized, both patient and family can benefit from:
  - CLEAR & SIMPLE EXPLANATION
  - FREQUENT OPPORTUNITIES FOR QUESTIONS AND DISCUSSION
  - REALISTIC REASSURANCE
Rehab and recovery

- Dealing now with the reality of lingering (or perhaps more permanent) loss of function, reactions and stress that revolve around:
  - FRUSTRATION AND DISCOURAGEMENT WITH LIMITATION AND SLOW IMPROVEMENT
  - IRRITATION WITH HOSPITAL ROUTINE
  - CONCERN ABOUT JOB AND FINANCES
  - WORRY/GUILT REGARDING IMPACT ON FAMILY
  - IMPLICATIONS FOR THE FUTURE

Stroke, stress, and mood.....

- All three are connected
  - Directly and/or indirectly
  - As cause and/or consequence
- Individuals differ in:
  - History
  - Predisposition
Depression and anxiety

- Incidence
  - General population: lifetime=15-17%
  - Post-stroke population=33%

  Important to get a good psychiatric history and any current/recent psych meds or psychotherapy

Symptoms of depression
Can have a negative effect for rehab and recovery

- Poor sleep or appetite
- Low energy
- Lack of motivation/initiative
- Decreased concentration/slowed cognitive processing/memory deficits
- Depleted self esteem, self critical
- Over focus on feelings/issues of loss (function, health/strength, independence, career, etc.)
- Thought of giving up, dying, suicide

Symptoms of anxiety

- Can have a negative effect for rehab and recovery
- Excessive worry
- Increased tension and irritability
- Symptom magnification/catastrophizing
- Panic attacks
- Poor concentration/distractibility
- Unable to relax/rest/sleep, feeling exhausted
- Unable to eat
Common psychological issues and concerns post-stroke

- Loss of career and related social network and status
- Loss of hobbies and interests
- Loss of role in marriage/family
- Being a “burden”
- Financial stress
- Frustration with being so limited

Family stressors and concerns

- Some common issues:
  - Recovery
  - Caregiving
  - Abrupt change in roles, responsibilities, added pressures
  - Planning
  - Finances/insurance/bills
- Crucial to provide family, as collaborators in care with
  - Appropriate emotional support in coping
  - Practical direction and assistance in accessing resources
  - Maintaining adequate self-care

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Role of rehab psychology

- Obtain a thorough history of psych issues and treatment, especially medication
- Get a good history of the person—character, beliefs, coping, interests, education, and values
- Assess and assist with coping
- Provide education about stroke and realistic expectations for rehab and recovery

Role of rehab psychiatry, cont’d

- Discuss issues, concerns, feelings, and help with management of depression and anxiety
- Help to maintain adaptive perspective
- Emotional support for the family
  - Help in addressing concerns and conflicts

In summary......