

Fall 2011
Volume 4, Issue 3



Stroke Nursing News

Special Interest Articles:

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Stroke Recovery Associations

Barber Shops and Blood Pressure

Best Practice Recommendation 1.1

Treating atrial fibrillation

PhD candidate Sarah Flogen

Conferences and other events

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Stroke Prevention – Get ready for the Tsunami

Those of you who read the Fall 2010 issue of the Stroke Nursing News have seen the following quote from Dr. Hachinski on the opening page of that issue. His words have stuck with me and are worth repeating. Dr. Vladimir Hachinski, an internationally recognized researcher and editor-in-chief of the journal *Stroke*, challenged the country's stroke specialists to work across disciplines, and outside the medical community, to further our knowledge and understanding of stroke. "We need a new approach to get ready to meet the "tsunami" of strokes that is coming as the population ages and our risk factors increase," says Dr. Hachinski. "It's time to think outside of doctor's offices and hospitals, and look at new ways we can prevent and manage strokes," he says.

Dr. Marco Di Buono, Director of Research for the Heart and Stroke Foundation echoes this sentiment. In a February 2011 press release by the Canadian HSF, he says, "Telling people to eat more vegetables and fruit is pointless unless governments, industry and organizations like the Heart and Stroke Foundation work together to make healthy food more affordable and



accessible to all Canadians."

He notes that individuals, families, schools, health care providers, communities, businesses, industries and government collectively play a role in improving the health of Canadians.

<http://smr.newswire.ca/en/heart-and-stroke-foundation/heart-and-stroke-foundation-2011-report-on-canadians>)

CTV news, reporting on the same HSF poll, said, "The Heart and Stroke Foundation's 2011 report card finds that while most Canadians know what a healthy lifestyle looks like, they're not necessarily living it. According to the poll of 2,000 adults that the Heart and Stroke Foundation conducted in December, most of us are overestimating our own healthy behaviours. "Living longer isn't much fun if you don't have your health. Making healthier choices and controlling the modifiable risk factors are key to extending quality years of life."

<http://www.ctv.ca/CTVNews/Health/20110201/heart-stroke-risks-report-card-110201/>

This issue profiles some individuals and organizations who are making stroke prevention – both primary and secondary – their business. Stroke Prevention Clinics and Stroke Recovery Associations across the country work to support stroke survivors for secondary prevention and better quality of life. Read the stories of Individuals making a difference to local and global community health, like Jean Senecal (page 4), who took primary prevention out into the local businesses, and Sarah Flogen (page 7), who hopes, with her research, to contribute to better healthcare access for the socially disadvantaged.

Every one of us has ideas on how to reduce our stroke risk and make ourselves and our communities healthier. Go to websites like this one, on Empowering Stroke Prevention: <http://www.selfhelp.on.ca/stroke/start-your-own.htm>

Organize a blood pressure clinic or a community walk. Offer to present a stroke information talk at the local library. Take the stairs instead of the elevator. Eat an apple instead of ... Hey, look at you, reducing your stroke risk!



Canadian Stroke Network

Réseau canadien contre les accidents cérébrovasculaires

Finding Stroke Prevention Clinics



British Columbia;
<http://find.healthlinkbc.ca/> and do a search for stroke prevention clinics

Alberta Stroke Services:
<http://www.albertahealthservices.ca/services.asp?pid=stype&type=34>

Saskatchewan:
http://www.heartandstroke.sk.ca/site/c.inKMLNIEmG/b.3671871/k.F9C8/Saskatchewan_Stroke_Programs_and_Groups.htm

Manitoba:
http://www.heartandstroke.mb.ca/atf/cf/{8AA02216-F223-439E-B498-5229E02AF420}/MB_Note_to_Physicians_stroke_prevention_clinics_available.pdf

Ontario:
info@ontariostrokenetw.ork.ca

Quebec:

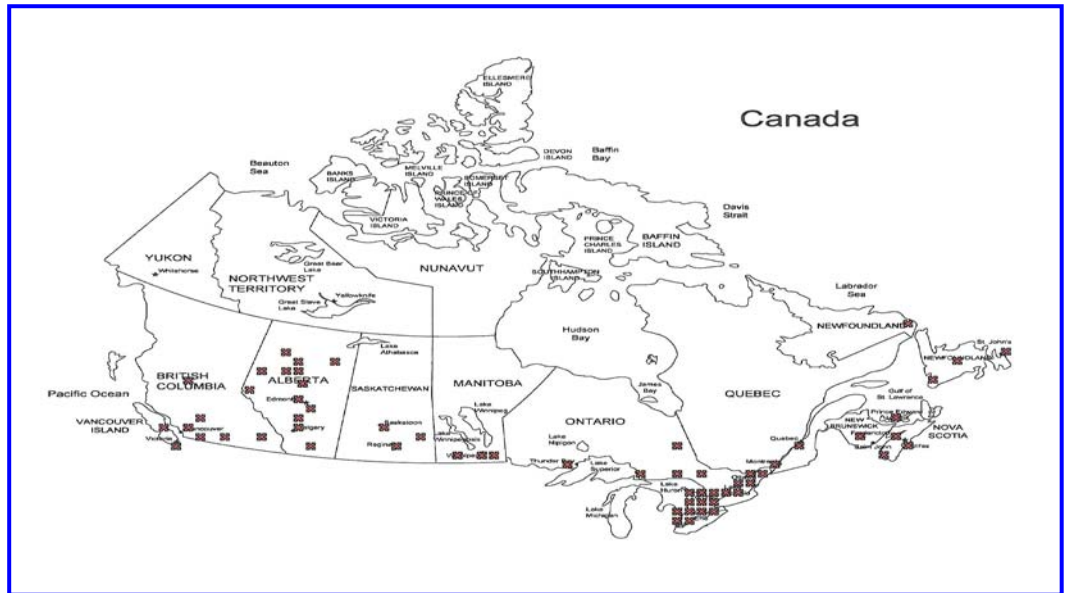
Nova Scotia:
http://www.gov.ns.ca/health/cvhn/available_services.asp

New Brunswick:

Prince Edward Island:
 Secondary Stroke Prevention Clinic Prince County Hospital:
 phone: (902) 438-4471

Newfoundland and Labrador: info@hsf.nl.ca

Stroke Prevention Clinics across the Country



What do Stroke Prevention Clinics do?

Stroke Prevention Clinics provide an integrated, comprehensive, interdisciplinary approach to stroke prevention through aggressive treatment of risk factors. It is for people with or without symptoms of stroke-related problems but who are at high risk for stroke. Clients are referred by family physicians, emergency room physicians or other hospitals and physicians within the region.

Most stroke prevention clinics have a mission to provide continuity of care for stroke patients, and their families, and to prevent stroke recurrence; to manage risk factors and provide a support system for those at risk of stroke.

They accomplish this by

offering timely clinic appointments to diagnose and treat stroke, and work with their patients to develop individual management programs for risk factors.

Neurologists, Stroke Nurse Clinicians or Coordinators, and sometime Stroke Fellows, do a medical history and examination, provide diagnostic testing and treatment, and ensure that high-risk stroke patients are rapidly triaged and treated.

Findings and recommendations about stroke management and related risk factors are sent to the family physician.

A supportive relationship between the involved health care professionals and the patient/family is developed. Many clinics have an interdisciplinary staff, for example pharmacists and dieticians, to assist in achieving

patient goals.

Patients may present with a TIA or minor stroke symptoms not requiring hospital admission or not requiring immediate neurological assessment. In most clinics, high-risk TIA patients are seen and treated on an urgent basis. The clinics also see many post-stroke patients, and will work with them to prevent another event, and to ensure they are referred for appropriate follow-up.

Awareness of community services provided for stroke patients is also essential for the clinic staff, enabling them to assist the patient in community reintegration.

The ABC's of Stroke Risk Reduction



Making Connections – Bridging the Gap

That is the aim of a 1-year pilot project funded by the Alberta Provincial Stroke Strategy (APSS). APSS is partnering with the Stroke Recovery Association of Alberta (SRAA) and Recreation Therapy resources within Alberta Health Services (AHS) to enhance the work of the Stroke Recovery Associations of four Alberta communities – Leduc, Camrose, Medicine Hat and Lethbridge – to support stroke survivors across the province. Four Recreation Therapists have been hired to work in each of the communities. They met with their groups to identify goals for the year, and now have ongoing meetings to strategize on how they will achieve their goals. The Recreation Therapists assist in liaising with and/or developing recreation resources, making contacts and also in educating stroke care providers about what the local Stroke Recovery Associations can offer their stroke patients.

Recognizing that they serve the same client population, the Stroke Recovery Association of Leduc and the Leduc Brain Injury Rebuilding Club (LBIRC) have joined together to bridge the gap between institutional rehabilitation and community reintegration. The Leduc SRA is working towards educating Edmonton and local health professionals about their SRA and the benefits of post-stroke support in the community in hopes that they will in turn facilitate connecting Leduc stroke survivors who are treated in Edmonton. They have partnered with a local retirement facility to share transportation into Edmonton for recreation services. A post-discharge community recreation connection group will begin in September. The Leduc SRA is also developing accessible recreation opportunities in partnership with the local recreation centre.

In Medicine Hat and Lethbridge, the recreation therapists, together with their local SRA have also provided education about the local SRA to health care professionals delivering services to stroke patients hoping to increase their awareness and the rate of stroke patient referral to SRA. To facilitate this, they have also been working on a consent process that would allow SRA members to visit stroke survivors in the inpatient setting. Partnership with acute care staff help to promote the local SRAs and increase the potential for stroke survivors to experience successful community reintegration with the help of peers.

Camrose had the unique position among the 4 pilot sites, of not having an existing local SRA at the outset of the project. The APSS recreation therapist, with assistance from SRA Alberta, was quickly able to recruit 2 individuals who are willing to lead the local SRA. To date, they have held 2 successful meetings with an attendance of approximately 17 participants.

The Leduc SRA members identify that most of the group's participants have heard about the Stroke Recovery Association's valuable post-stroke support services through word-of-mouth. Most people make the most progress in the first three months after a stroke. However, recovery may continue for up to 3 years.¹ As such, among other goals the recreation therapists and their SRA's are working on developing a patient referral process, with the intent of linking stroke survivors into the support group within a month of discharge and developing additional and compiling existing community recreation resources. Many times, clients do not access programs and services because they are unaware of what is out there for them. The groups are also exploring transportation resources that will enable stroke survivors to attend various community-based programs, including those in neighbouring communities with more stroke-focused programs. The pilot project is also fortunate to have had their abstract accepted for the 2011 Canadian Stroke Congress in Ottawa, from October 2-4, where their poster presentation will be presented.

The different groups provide recreational and educational offerings and knowledge about what is available in their community. Most importantly, though, they provide support. "Support groups foster positive physical and emotional healing through peer support by offering a social setting for patients and caregivers to interact and share experiences. Together, they explore challenges in communication, patient independence, role changes for caregivers and stroke survivors, and the importance of having strong a social support network."²

If you know someone who has had a stroke, contact the local Stroke Recovery Association at SRAA1@live.com, or

- Leduc SRA: Sarah.james@albertahealthservices.ca
- Lethbridge SRA: Carolyn.matthews@albertahealthservices.ca
- Medicine Hat SRA: Lanna.herter@albertahealthservices.ca
- Camrose SRA: Heather.hillis@albertahealthservices.ca

"Stroke survivors need support", says Sarah. "They need to see the benefits of joining a stroke recovery association. Life continues after stroke. [They need to know] Here's what it could look like."

1. http://www.swostroke.ca/content/files/Rehab_After_Stroke_Community.pdf
2. http://healthonecares.com/stroke_center/life-after-stroke/

The Camrose and Area Stroke Recovery

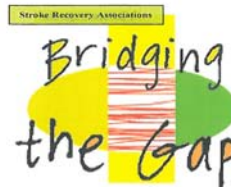
Association is a newly-formed group. Their second meeting, July 14, included a BBQ and social. Almost 80% of this fledgling group is under 65. "They're a vibrant and motivated group", says Heather. Plans for the fall include a trip to the local Corn Maze on Thursday September 8. Meet at the Camrose Fire Hall at 11:30 to car pool. Contact information is: Facilitator Sandra McLay, mclay.sandra27@hotmail.com, ph. 780 608-7658 or Heather Hillis, heather.hillis@albertahealthservices.ca, ph. 780 679-2943. Meetings of the Camrose & Area Stroke Recovery Association will be monthly on the second Thursday of the month. Time may vary depending on the activity planned. Contact Sandra or Heather for more information.

The **Leduc** SRA meets the first Monday of the month at the Leduc Civic Centre. Contact Sarah for more information.



Medicine Hat has meetings the first Monday of every month. Contact Lanna for more information.

The **2 Lethbridge** groups meet once a month, September through May, then wind up the year together with a June potluck. The Young survivor group meets on the second Wednesday of each month at 7PM (Geared for survivors under 55, some older survivors attend this meeting because the time is more convenient). The Senior survivor group meets at 2PM on the second Monday of each month. (Younger survivors are welcome to attend this meeting if the time is more convenient.) Both groups meet at the Lethbridge Senior Citizens Organization (LSCO). Contact Louise Landry at Isra@shaw.ca or by phone at 403-317-2903, or email Carolyn @ AHS address.



Provincial Stroke Recovery Associations

Click on the links for information about SRAs in your area:

British Columbia: office@strokerecoverybc.ca

Alberta: sraa1@live.ca or www.strokealberta.com

Saskatchewan: healthpromotion@hsf.sk.ca

Manitoba: info@strokerecovery.ca

Ontario: <http://www.hamiltonstroke-recovery.ca/chapters.htm>

Quebec Stroke Recovery Association: 514-645-2915

Nova Scotia: <http://www.heartandstrokedirectory.ns.ca/>

New Brunswick: <http://www.marchofdimes.ca/EN/programs/src/supportgroups/Pages/QNSNBSupportGroups.aspx>

Prince Edward Island: <http://princeedwardislandstrokerecovery.blogspot.com/2011/04/stroke-education-suppliment-in-canadian.html>

Newfoundland and Labrador: skeats@hsf.nl.ca

CHEP 2011 Important Role for Home Management of Blood Pressure

Encourage hypertensive patients to use an approved blood pressure monitoring device and use proper technique to measure blood pressure at home.

Measuring blood pressure at home has a stronger association with cardiovascular prognosis than office based readings.

Home blood pressure measurement can confirm the diagnosis of hypertension, improve blood pressure control, reduce the need for medications in some, screen for white coat and masked hypertension, and improve medication adherence in non adherent patients.

An internet based toolkit for home blood pressure measurement including recording and tracking blood pressures can be found at www.heartandstroke.ca/bp



Patient information on selecting an approved device and how to track and record blood pressure can be found at www.hypertension.ca/bpc

Benefits of home blood pressure monitoring (or barber shop monitoring?) include rapid confirmation of the diagnosis of hypertension, better prediction of cardiovascular prognosis, diagnosis of white coat and masked hypertension, reduced medication use in white coat effect, improved adherence to drug therapy and better blood pressure control.

from the 2011 Canadian Hypertension Education Program Recommendations.

Blood pressure check with that haircut?

Jean Senecal, Nurse Educator, RN, BScN., KTHR, Melfort, Sk.

An interesting article in the New York Times reported a striking success. When barbers checked their male patrons' BP on every visit, the men were far more likely to see a doctor and get high blood pressure under control. (There was also a financial incentive: a free haircut for those who returned with a prescription.)

As a part time nurse educator focused on hypertension, I started bouncing the idea around in my own head. How could I incorporate this into my job and businesses within our health region? How many people could I see in a few hours, is it worth the effort? Which device should I use, an auscultation technique or digital? Would clients be interested or annoyed? The first step was to pick a starting point, one hair salon that had several cutters, nail specialists and tanning bed. It was also easier that I knew the owners, but truly didn't want to be a bother for them or their clients. A date during February for Heart and Stroke month was arranged with the salon. Also, we picked a time, 1-6 pm, when the most cutters would be available, so I would have the most traffic. An evening was ruled out as only one staff member was working each evening, making traffic low.

I opted for a brand new home digital device, as medical digital devices were out of my price range and auscultation devices are only useful for trained professionals. One of my goals was to show clients how easy it is to monitor your

own BP at home and I was doing screening, not diagnosis and treatment.

Space was limited so advertising was limited to posters at the salon and some around the city. I did not have anyone come that wasn't booked for an appointment with the salon. The day went well. I took printed resources, models and offered a door prize which asked for email addresses for future mail-outs. Most people were happy to get their BP checked. One refused. All participants received a BP card with their BP recorded on each arm. Teaching was done while they waited, and printed resources were offered. The door prize was drawn and given away a few days later. The people who shared email addresses all received an email that included a thank you for participating, the winner of the door prize and information about future hypertension education days. The salon owner was happy with the day and said I could come back another time.

I felt the day was successful because I did screening and teaching with people who see their hair dresser more than their doctor. I'm currently planning future screening events in other towns within our region.

Editor's Note: Jean's project was inspired by the study in the following article:



Awareness: Blood Pressure Check With That Haircut?

Barber shops often serve as a pipeline for health information in African-American communities. Now, a study reports a striking success: when barbers check their male patron's blood pressure on every visit, the men were far more likely to see a doctor and get high blood pressure under control. (There was also a financial incentive: a free haircut for those who returned with a prescription.)

The study, published online Monday, October 25, 2010 in Archives of Internal Medicine, was conducted at 17 black-owned barber shops in Dallas County, Texas, over the course of 2 years, ending in 2008.

Eight shops distributed pamphlets to customers found to have high blood pressure at the start of the study; nine went much further, offering blood pressure checks and urging hypertensive customers to see a doctor.

By the end of the study, more than half of both groups had their blood pressure under control. But the gain was more impressive among those whose barbers checked them at each haircut: 53%, from 33% at the start of the study, compared with 51%, from 40%, for those who received pamphlets.

Most customers were regulars who came in every 2 to 4 weeks, said the study's lead author, Dr. Ronald G. Victor, now of Cedars-Sinai Heart Institute. "That sure puts the issue on top of our radar screen," he said.

Best Practice Recommendations in this Issue

*Best Practice Recommendation 1.1: Symptom Recognition and Reaction

(The full recommendations can be found at www.strokebestpractices.ca)

All members of the public should be able to recognize the warning signs and symptoms of stroke, and react immediately by calling 9-1-1 or their local emergency number.

- i. Public education on stroke should emphasize that stroke is a medical emergency and that immediate medical attention should be sought. All members of the public should know how to take the appropriate action—that is, to call 9-1-1 or their local emergency number [Evidence Level B]. Refer to Box 1.1 for the signs and symptoms of stroke.
- ii. Public education should include information that stroke can affect persons of any age from newborns and children to adults and be aware of the benefits of early medical attention [Evidence Level C].

Box 1.1 Warning Signs and Symptoms of Stroke

Heart and Stroke Foundation of Canada, www.heartandstroke.ca

- Weakness:** Sudden weakness, numbness or tingling in the face, arm or leg
 - Trouble speaking:** Sudden temporary loss of speech or trouble understanding speech
 - Vision problems:** Sudden loss of vision, particularly in one eye, or double vision
 - Headache:** Sudden severe and unusual headache
 - Dizziness:** Sudden loss of balance, especially with any of the above signs
- ACTION: Call 9-1-1 or your local emergency number IMMEDIATELY**



Rationale

When it comes to stroke, *time is brain!* Stroke is a medical emergency. Most people do not recognize the five main symptoms of stroke and therefore do not seek immediate medical attention. It is critical that people with ischemic strokes (caused by a blocked artery) arrive in the emergency department as soon as possible, and within at least 3.5 hours of symptom onset, if they are to be eligible to receive clot-busting treatment. In the case of strokes caused by hemorrhage or leaking arteries in the brain, earlier assessment and treatment may allow time for life-saving intervention. Efforts to enhance emergency medical system response to stroke calls and to encourage the public to recognize stroke signs and symptoms and contact emergency medical services result in timelier treatment and better outcomes.

System Implications

- Public awareness initiatives focusing on the signs and symptoms of stroke, the sudden nature of the onset of signs and symptoms, awareness that not all signs or symptoms need to be present or that they may start to fade.
- Enhanced collaboration among community organizations on public education of the warning signs of stroke with a strong emphasis on the urgency of responding when the signs and symptoms of stroke are recognized.
- Training and education for emergency medical services, physicians, and nurses to increase ability to recognize potential stroke patients and provide rapid assessment and management.
- Heightened emergency response with appropriate protocols.

Performance Measures

1. Proportion of the population aware of two or more signs of stroke (*core*).
2. Median time (hours) from stroke symptom onset to presentation at an emergency department.
3. Proportion of the population that can name the three main stroke symptoms — sudden weakness, trouble speaking, vision problems.
4. Proportion of patients who seek medical attention within 3.5, 4, and 4.5 hours of stroke symptom onset (*core*).
5. Proportion of emergency medical service providers trained in stroke recognition and the use of stroke triage algorithms for prioritizing stroke cases for transport within regions.
6. Proportion of the population with a family member who has had a stroke or transient ischemic attack that can name two or more signs and stroke symptoms.

Measurement Notes

- Performance measures 1 and 2: Data may be obtained from Heart and Stroke Foundation public polls.
- Performance measure 3: Data may be obtained from chart audit data.
- Performance measure 4: The unit of analysis may vary depending on the emergency health services management model used in the province or territory.
- Performance measures 3 and 4: Stroke symptom onset may be known if the patient was awake and conscious at the time of onset, or it may be unknown if symptoms were present on awakening. It is important to record whether the time of onset was estimated or exact. The time qualifies as exact provided that (1) the patient is competent and definitely noted the time of symptom onset or (2) the onset was observed by another person who took note of the time.
- Performance measure 5: Data sources include emergency department triage sheet or admission note, history and physical examination, consultant notes, emergency medical services ambulance records.

TIA patients with speech difficulties more likely to suffer from irregular heartbeat

Patients who have a mini-stroke accompanied by speech problems are more likely to suffer from a treatable heart condition called atrial fibrillation, according to Ottawa research presented at the International Stroke Conference. Dr. Mukul Sharma, deputy director of the Canadian Stroke Network and author of the study, said that speech problems "provide a clinical clue for physicians, alerting them to the need to look early and suspiciously at the heart" as the origin of a mini-stroke, or transient ischemic attack (TIA).

TIA patients have a 10% risk of a major stroke within 90 days, with half of strokes occurring in the first week. That's why identifying the cause of TIA quickly and effectively is critical. Atrial fibrillation is a common and treatable risk factor for stroke but it frequently goes undetected.

Dr. Sharma and his team studied 1,369 patients with TIA treated in The Ottawa Hospital's emergency department. Of these patients, 48 were identified as having speech difficulties. The study found that these patients were twice as likely to have had a blood clot that originated in the heart than other TIA patients (20.8% vs. 10%).

Dr. Sharma is also director of The Ottawa Hospital Stroke Clinic and an assistant professor of neurology at the University of Ottawa.

Reprinted with permission from a Canadian Stroke Network news release.

New atrial fibrillation treatment uses cold instead of heat

CTV.ca News Staff

Date: Wed. May. 11, 2011



Health Canada has just given its approval to a new made-in-Canada treatment for atrial fibrillation that uses liquid refrigerant to freeze heart tissue, allowing the heart to return to its regular pace.

The treatment is called Arctic Front Cardiac CryoAblation Catheter system and it was developed by Medtronic in Montreal for patients with atrial fibrillation.

A-Fib is a condition in which the heart's two upper chambers (the atria) quiver instead of beating. Because blood isn't pumped completely out of the chambers, it can pool and clot, perhaps leading to a stroke. In fact, about 15 per cent of strokes occur in people with atrial fibrillation.

While there are drugs to treat the condition, they don't always work, requiring a procedure called radiofrequency ablation. Radiofrequency ablation involves inserting a flexible catheter into the heart muscle, either directly or up from the

groin through blood vessels. Then, a burst of radiofrequency energy destroys the tissue that triggers abnormal electrical signals or that block abnormal electrical pathways.

Cardiac cryoablation is different because it uses extreme cold to do the same thing. The catheter tip is filled with liquid coolant which expands to a gas that causes the tip to cool to a very low temperature. The catheter freezes the nearby heart tissue around the pulmonary vein, thereby blocking the abnormal electrical activity.

Because it doesn't use heat, its developers say cardiologists can treat patients more quickly and efficiently.

Normand Beaulieu, 59, had the procedure in August 2007 while taking part in a large clinical trial conducted at the Montreal Heart Institute. He had had atrial fibrillation since he was 43. The medications didn't work for him so that by the time he was 56, he was getting symptoms two to three times a week. The symptoms would sometimes last for a day or longer, leaving him feeling short of breath, weak and dizzy.

The surgery, he says, was simple.

"I went to the hospital on a Wednesday, got the surgery on a Thursday, they got rid of me on the Friday and on the Sunday, I played golf. And I finished my basement the week after," he says.

"I have regained the life I had before."

Not only does Beaulieu have few A-Fib symptoms, he's also been freed from a regimen of expensive drugs and regular visits to the emergency room.

The study that Beaulieu was part of, called The STOP AF trial, showed that 69.9 per cent of patients treated with Arctic Front were free from atrial fibrillation at one year, compared to 7.3 per cent of patients treated with drug therapy only.

The study also found there were few procedure-related adverse events (3.1 per cent). Patients also showed a substantial improvement in both physical and mental quality-of-life.

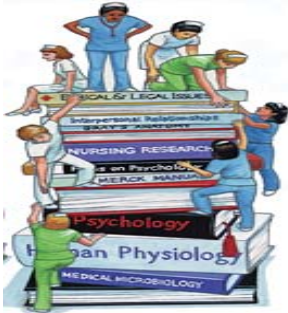


The cryoablation balloon inside a patient's heart.

Meet a nurse who has followed her passion

By Colleen Taralson

Stroke Nurses to Know



The Stroke Nursing News introduced this feature in Spring 2008. We would like to continue to profile Canadian nurses who have completed or are currently enrolled in doctoral studies and have a focus on stroke.

One of the goals of these articles is to help build a community of nurse scientists in Canada and to encourage nurses who might be contemplating doctoral studies by introducing them to mentors and role models. We sincerely appreciate the candor and support of those nurses who have agreed to be profiled.

Special thanks to Kenda Power in Saskatchewan for the idea. If you know a nurse who should be profiled here, please send your ideas and articles to the editor at Colleen.taralson@albertahealthservices.ca



Oxford University Press online: “An intense desire or enthusiasm for something.”

“Follow your passion, whatever that may be. Be who you are, wherever you are, and you will be in the right place.” These words, which remind us to live in the moment and be the best that we can in that moment, were spoken just this morning by Sarah Flogen, Nurse Manager of an inpatient psychiatric unit and PhD candidate at the University of Toronto School of Nursing. Sarah’s passion for her work on social determinants of health and health equity was evident even in our brief but absorbing telephone interview.

Sarah, fresh out of high school, graduated from a two and a half year diploma of nursing program at Humber College in Ontario, in the days of white uniforms with white nylons and shoes, and a cap which she remembers knocking on IV poles. While working in Toronto, she heard that a Bachelor of Nursing would soon be required for entry-to-practice and enrolled in a post-diploma program at McMaster University. She drove between her full-time job in an ICU in Toronto, and her classes at McMaster in Hamilton for 2 years, and recalls being “blown away” by how the BScN opened her eyes to other

areas of nursing that she didn’t know about, for example the OH&S nurses concerned with the healthcare needs of Hamilton factory workers.

Upon completing her BScN, Sarah worked for a time among the native population of Bear Skin Lake in northern Ontario. Working in this remote aboriginal community exposed Sarah to a very different lifestyle with different determinants of health. Although Sarah was a young, inexperienced nurse, perhaps the idea of social determinants of health, which would eventually lead to her PhD studies, took hold in her receptive brain. Sarah says that throughout her career, education has been important. As she learns new things, more doors open up. Learning is a life-long pursuit.

Sarah returned to Toronto, and she made the decision to move to Muskoka and start a family. Sarah chose not to work at this time, focusing on raising her children, but did volunteer work, which allowed her to take the children with her. She began volunteering in a program for at-risk youth, and often felt frustrated and inadequate when they came to her with problems and difficult life situations, and she didn’t know what to say to help them. This experience led her into the area of psychology, and she pursued a Masters of Clinical Psychology at OISE (Ontario Institute for Studies in Education) at

the University of Toronto. She learned communication and interpersonal relationship skills, and how to create safe spaces where individuals could be themselves. This was also another stepping stone in her understanding of different perspectives of health.



Sarah completed her Masters and took a position in the local emergency department, putting her skills to use in providing psycho-social support for patients and families. It wasn’t long until, once again, the desire to move forward, to grow and learn, took hold and Sarah enrolled in an advanced practice nursing course, intending to gain more independence and autonomy in her work by becoming a Nurse Practitioner. A practicum in Neurology at Sunnybrook Hospital introduced Sarah to the world of stroke nursing, which she discovered she loves. Her counseling skills helped her support patients and their families through the trauma caused by stroke. This was during the early days of the Ontario Stroke Network and Sarah says the team she worked in was wonderfully collaborative and supportive, and gave her a solid grounding in medical learning. Continued on page 9

Save the Dates



2nd Canadian Stroke Congress, Ottawa Convention Centre, Oct. 2-4, 2011

www.strokecongress.ca

Stroke Collaborative 2011



Metro Toronto Convention Centre, Oct. 17, 2011

http://www.heartandstroke.ca/site/c.pv13leNWJwE/b.5338999/k.6D27/HCP_Stroke_Collaborative.htm



2011 Canadian Hypertension Congress, October 2-5, 2011, Alliston, ON.

www.hypertension.ca/chs/meetings/annual-meeting-2011/

albertaREHAB2011

November 4-5, 2011, Shaw Conference Centre, Edmonton

<http://www.buksa.com/albertarehab/index.htm>



New Orleans, La. Ernest N. Morial Convention Ctr

http://my.americanheart.org/professional/Sessions/InternationalStrokeConference/International-Stroke-Conference_UCM_316901_SubHomePage.jsp

CANN 42nd Annual Meeting and Scientific Sessions

held in Vancouver, June 14-17, 2011

Stroke 101: Delivering stroke education for prevention of first stroke (primary) or subsequent stroke (secondary) in the community

Presented at the 2011 CANN conference by Andrea Cole-Haskayne Developed in collaboration with Ev Glasser, HSF-AB and Michael Suddes, Mgr., Calgary Stroke Program



Stroke 101 is an educational program developed in alignment with current best practice standards and one goal of the Alberta Provincial Stroke Strategy, which is "to reduce the rate which individuals have stroke in Alberta". The program was developed after gaps in primary stroke risk reduction education for the public were identified, and is open to everyone wanting to know more about stroke and how to prevent it. Delivered in a community setting in partnership with Living Well, within Chronic Disease Management (CDM) services, and facilitated by Neuroscience Nurses, this 2 hour interactive workshop is ideal for individuals with risk factors for stroke.

Living Well registers participants and arranges facilities in the community. Class size is limited to no more than 20 participants to enhance interaction. Class content includes basic stroke knowledge, recognition

and response to the signs of stroke, acute treatment for stroke, stroke risk factors and risk reduction strategies.

The program begins with a 30 second video from the National Institute of Neurological Disorders and Stroke (NINDS) to alert participants that stroke is a medical emergency.

<http://stroke.nih.gov/material/s/ambulancevideo.htm> Participants complete Stroke Risk Score Card to assess their risk, adapted from Stroke Risk Scorecard, National Stroke Association. www.stroke.org. Once clients identify their risks, they start building an action plan to reduce their risk. High risk clients are encouraged to make an appointment with their family doctor ASAP.

The Action Plan is in alignment with Canadian Best Practice Recommendations (APSS, 2009; Canadian Stroke strategy, 2010), and covers all risk factors for stroke. Participants select a goal for each risk factor, and the action plan lists steps to accomplish each goal. Participants are challenged with the question, "What one thing can you start today to reduce your risk of stroke?" They are encouraged to make lifestyle modifications and discuss their risk factors with a health care professional.

Course content is reinforced by concluding with "Know Stroke Video"

<http://stroke.nih.gov/material/s/knowstrokevideo.htm> Participants were asked to complete a simple evaluation form, rating the course from 1-5. Ten courses have been

delivered so far, with class sizes between 4 and 23, and the overall rating the course has received is 4.7. There are many challenges to delivering courses like this. Participant recruitment is often difficult; lack of an advertising budget; organizers can't always get optimal dates, times or facilities; participants often don't want to pay for parking. But the successes, such as partnering with Chronic Disease Management, and reaching beyond stroke patients into the community make the efforts worthwhile.



(L - R) Andrea Cole-Haskayne and Ev Glasser; Strathmore Library presenting Stroke 101; photo by: Robert Massey, The Strathmore Standard Reporter

The group has brainstormed a number of initiatives to increase enrollment, like individualized patient letters (used previously with success), invitations to patients on (in-patient) units and advertising in community bulletins/websites. They also plan to increase staff awareness of the program through in-services, email, and posters on the units. A wording change in their brochure, from "For people at high risk of stroke or looking for more information about stroke and TIA" to "For anyone wanting information on how to prevent stroke/TIA (Transient Ischemic Attack) and what to do if someone you know is having a stroke" may generate increased public interest as well.

Contact Andrea at Andrea.cole-haskayne@albertahealthservices.ca for more information.

Continued from page 7: PhD candidate Sarah Flogen:

This, coupled with her understanding of the psycho-social aspects of a patient's experience, led Sarah to start seeing beyond the medical event to the narrative, the patient stories, behind the event.

A turning point in her understanding of the diversity of experience and perception behind the patient's experience of medical events came one day when she walked into a stroke patient's room with some "helpful" resources. She describes herself as a white middle-class female, holding out a handful of resources filled with pictures and information for white, middle-class Canadians, to the son of a middle-Eastern women, sitting cross-legged on the bed, speaking no English and interpreting her health through a different cultural experience, and she again felt inadequate and embarrassed by the disconnect between what the patient needed and what she was offering. Toronto's population is very diverse and multi-cultural, offering Sarah many opportunities to realize that the medical system was not responding adequately and with equality to all patient's needs. She made the decision not to write her final Nurse Practitioner exam, but instead to pursue a PhD in Nursing, looking at the

many different health determinants in different population groups through a method of inquiry called "Institutional Ethnography" (http://en.wikipedia.org/wiki/Institutional_Ethnography). Sarah's study, still ongoing and summarized in the sidebar, explores the experience of socially less advantaged Torontonians who experience a possible TIA or minor stroke as they navigate the stroke system, from the patient's perspective. Still in it's early days, the results of this study and others like it, have the potential to influence clinical practice through education of healthcare providers, changing the way we deliver healthcare and the resources we use for patient education.

I asked Sarah what her biggest challenges were in returning to school for a PhD. She said it was "scary". It was so new, and each piece of the process had a new hurdle to overcome – "Can I write?" "Do I really understand this article?" "Can I defend a PhD?" She was so scared and excited after her first interview that she didn't sleep that night.

Sarah also embarked on the daunting task of finding funding for her PhD pursuits. It is not only a huge personal financial commitment but a time commitment also, as writing letters for grant funding can be a long and difficult process. Her children, at 17 and 19, are less reliant on her, but family time is impacted. A supportive home and work environment is important, especially since Sarah sometimes needs to interview patients during her working hours. She is grateful for an employer who allows her to both work and continue her studies.

Relationship-building is a vital part of pursuing a PhD. Collaborative relationships with her advisory committee, trusting relationships with patients and their families – these are so important for successful completion of any PhD program. Sarah also said that finding time to buy and read all the books she needs, and then finding the cognitive vacant space to ruminate on and process what she has read can be challenging, and takes commitment.

So, what are the rewards? She loves learning. Her own learning has been invaluable, and has contributed to and shaped other relationships. She values the opportunity to be a role-model for her children, demonstrating what a life-long love of learning can accomplish, both personally and professionally.

Sarah has learned how to deliver a sound argument and to defend her ideas. She now has informed opinions, which she can back up with solid rationale. She has grown academically, and deepened her knowledge, and says that participating in a field of study has been very rewarding.

Collaborating with a team has been invaluable. Sarah is so grateful for the people she gets to work with, especially her supervisor, Dr. Sioban Nelson, Dean, Faculty of Nursing, University of Toronto.

Sarah rides the subway to work every day, and says, "I love the city because of the music of the languages around me."

She loves the diversity and wants her work to respect that diversity. She plans to complete her PhD, and then look for a role where she can utilize her learning and her love of strategy to help make the health system more user-friendly. She believes that when she is ready, that door will open up, and she will walk through it, and continue to follow her passion.

Social disadvantage and stroke prevention -Sarah Flogen

Sarah was working as NP in stroke and gave an information booklet, designed for the average white Canadian, to a recent immigrant. This started her thinking more critically about the process of a person within an "institution".

There is a disconnect between the individual and the institution. The individual has a 'real life, with work, kids, culture, religion, food, health beliefs and a socioeconomic status. They might feel anxious or threatened when in the hospital. Institutions have clinic hours and standardized information. Clients may be confronted with the idea of self-management and expected to make lifestyle changes they do not embrace.

The goal of Sarah's study is an exploration of the disjunctures between the individual and the institution from the standpoint of the individual with transient ischemic attack or minor stroke, and to look at how is Stroke Prevention is socially organized.

Sarah uses the research method of Institutional Ethnography. Developed by Dorothy Smith in the 1990s, this method starts in the standpoint of the individual and describes the work of the individual, examining the link to the external through texts. Participants may be included in the study if they have been referred to clinic for TIA or minor stroke, are able to communicate using English, have a high school education or less, are unemployed, are a visible minority, are a single or divorced woman working part time, are a person with previous a functional limitation/disability, are obese as identified by waist circumference or are a recent immigrant – 4 to 5 years in Canada.

National Updates



The Canadian Stroke Network has released its 2010-11 Annual Report. Go to <http://www.canadianstrokenetwork.ca/index.php5/news/2010-11-annual-report/> to download the full report, read it on-line or obtain printed copies.



30-Day Cardiac Event Monitor Belt for Recording Atrial Fibrillation After a Cerebral Ischemic Event (EMBRACE): A Randomized Controlled Trial

The CSN-funded EMBRACE trial, underway at 18 Canadian sites, is investigating cardiac monitoring strategies to improve the early detection of occult atrial fibrillation in patients with a recent unexplained ischemic stroke or TIA. In just over 2 years, 400 patients have been enrolled and recruitment is ongoing to reach the planned sample size of 564. For more information, or if you wish to refer a potential candidate to a study site for participation, please contact study PI, Dr. David Gladstone at david.gladstone@sunnybrook.ca or visit www.clinicaltrials.gov (NCT00846924).



The 2nd Canadian Stroke Congress

took place in the Ottawa Convention Centre October 2-4, 2011. The purpose of the Congress was to provide a uniquely Canadian forum in which participants reflecting “bench-to bedside-to-community” perspectives of stroke could exchange ideas, collaborate, and learn about innovation in stroke prevention, treatment, and recovery.

More than 900 of the top stroke researchers, clinicians and policy experts from across Canada and around the world gathered at the Congress to tackle issues related to stroke, a leading cause of death and disability in this country.

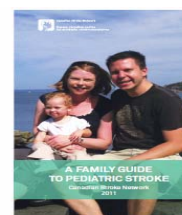
Dr. Sandra Black, Director of the neurosciences research program at Sunnybrook Research Institute in Toronto, presented the 8th Annual Ramon J. Hnatyshyn Lecture on the morning of October 4. Dr. Black unraveled the link between Alzheimer’s and cerebrovascular disease.

Everyday, 1,000 people in Canada turn 65, entering a stage of life that has increasing risk of stroke and Alzheimer’s disease.

“Recent national and international imaging studies on the brains of people aged 65 and older show that 95 per cent have brain small vessel disease seen as white spots and patches on magnetic resonance images,” says Dr. Sandra Black, director of the Brain Sciences Research Program at Sunnybrook Research Institute at the University of Toronto. These studies also show that a quarter of healthy senior volunteers, average age 70, living in the community, have evidence of small silent strokes. Even in younger people (average age 60), this number may be as high as 14 per cent, according to preliminary results of the Canadian PURE MIND study, presented at the Canadian Stroke Congress.

Watch for more on the Congress in the next edition of Stroke Nursing News, or go to <http://www.canadianstrokenetwork.ca/index.php/news/>

The Canadian Stroke Network releases its brand new resource “A Family Guide to Pediatric Stroke”

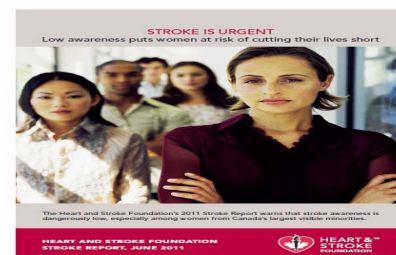


Available in both French and English, and based on the Canadian Stroke Best Practice Recommendations for Stroke Care (2010), “this guide was designed to provide basic information about stroke and stroke care to families of children who have had a stroke.”

Dr. Patrice Lindsay, Performance Evaluation Specialist, Canadian Stroke Network, especially acknowledged the contributions of Sonia Rothenmund, Pediatric Stroke Nurse, Alberta Children’s Hospital, Calgary and Ivanna Yau, Advanced Practice Nurse, Stroke Program, Division of Neurology, The Hospital for Sick Children, Toronto.

More in the next Stroke Nursing News. Access the guide at www.canadianstrokenetwork.ca/

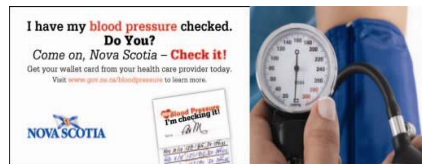
STROKE IS URGENT: The Heart and Stroke Foundation 2011 Stroke Report warns stroke awareness is dangerously low among women



Ottawa, June 1, 2011 – The Heart and Stroke Foundation 2011 Stroke Month Report warns that awareness levels of stroke warning signs and stroke prevention is dangerously low among all women, especially among women from Canada’s two largest visible minorities – people of Chinese and South Asian descent.

<http://www.heartandstroke.com/site/apps/nlnet/content2.aspx?c=iklQLcMWJtE&b=7498307&ct=10858179&src=home>

Nova Scotia Launches My Blood Pressure Card



Three provincial programs (Cardiovascular Health Nova Scotia, the Diabetes Care Program of Nova Scotia, and the Nova Scotia Renal Program) have worked to develop, pilot test, print and distribute My Blood Pressure Card Campaign tools across Nova Scotia.

The tools include a wallet card, brochure, and poster for the office/work setting to help increase patient and health care provider awareness about hypertension. The campaign and tools will assist to:

- Engage individuals in self-care practices
- Promote the need for routine monitoring of blood pressure and an awareness of "knowing your numbers" as a means of primary prevention
- Reinforce consistent messaging across provider groups including "Tips" to lower blood pressure: sodium reduction, healthy eating, healthy weights, physical activity, smoking avoidance, alcohol moderation, stress reduction, and medication management.

Modeled after a successful project at the Valley Regional Hospital Diabetes Centre, Annapolis Valley Health, the project focuses on hypertension, its risks, prevention, early identification and optimal management. With the assistance of the District Health Authorities the materials have been distributed to ambulatory and specialty clinics, collaborative practices, physicians, pharmacists, health charities and others. The official launch of the My Blood Pressure Card Campaign took place in August 2011. For more information please visit the website:

www.gov.ns.ca/bloodpressure



Heart and Stroke Manitoba sponsored a 2-day workshop (Sept. 14 and 15th, 2011) for nurses involved with Stroke Care. Laura MacLissac travelled into the North, to Thompson, to repeat the workshop there.

Manitoba Health has hired 5 people to work part time over the next 6-12 months to review and report on the 5 areas of Stroke Care in Manitoba (EMS, Acute, Post acute, Rehabilitation, and Stroke Prevention). This review should help identify the gaps and create a strategy to address them. This is a big provincial step forward for stroke in Manitoba.

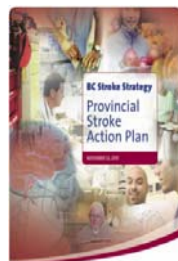


Finding answers. For life.

PEI is very busy planning for the implementation of provincial ambulatory stroke rehabilitation services targeted for October 2011. A provincial ambulatory stroke rehabilitation clinic will work collaboratively with the provincial acute stroke unit, provincial stroke rehabilitation unit and with the two district ambulatory stroke rehabilitation teams to offer stroke survivors specialized treatment programs based on clinical and scientific evidence. These specialized teams will provide early supportive discharge for appropriate post stroke patients.

Ongoing evaluation and monitoring of stroke care is a priority to shape PEI's stroke care strategies and system refinement. We are in the process of establishing efficient and cost effective processes for data collection and reporting of key indicators.

Health PEI continues to partner with the Heart and Stroke Foundation of PEI to coordinate and integrate stroke resources, ensuring Islanders have access to high quality and sustainable organized stroke care across the continuum. Our "One Island Health System" enables us to transition stroke survivors province-wide in a seamless, coordinated and well-planned fashion.



The BC Stroke Strategy Action Plan was completed on November 23, 2010 and formally submitted to the provincial government and the Health Authorities for review, decision-making and implementation.

The BC Stroke Strategy Action Plan outlines how specific BC Stroke Strategy initiatives would be rolled out across the province, including: investing in additional clinical services to follow up on Transient Ischemic Attacks (TIAs, or mini strokes) to divert or delay a full blown stroke; designating acute care facilities according to their capacity to provide levels of stroke care; organizing pre-hospital, ambulance and emergency departments to support optimal stroke care; expanding Telestroke across BC, which will support sites without access to stroke specialists and help contribute to a tPA-enabled health care system; co-horting stroke patients in designated stroke treatment units; providing optimal inpatient rehabilitation care and early home-supported discharge and community reintegration, when appropriate; and improving human resource capacity and education for stroke care in BC.



Albertans will soon have more support to maintain or move toward a healthy weight, including improved access to bariatric surgery, with today's launch of the Alberta Health Services (AHS) Obesity Initiative.

The comprehensive, five-year plan will help Albertans manage weight issues in a planned and coordinated manner and, at the same time, will introduce a broad range of programs to help prevent obesity. Obesity affects about one million Albertans, or approximately 25 per cent of the province's population. The initiative includes a suite of services, from community-based programs to intensive medical intervention, all designed to reduce the burden of obesity. Currently, obesity is estimated to cost Alberta more than \$1.4 billion annually in terms of reduced quality of life, a high rate of co-morbidities, loss of workforce productivity, and cost to the health care system.

Obesity is the most pervasive, progressive and serious of chronic diseases facing our province. It is linked to 22 other chronic diseases, including up to 90 per cent of all Type 2 diabetes, up to 30 per cent of cancers, and 80 per cent of cardiovascular disease. "This initiative involves a comprehensive approach that recognizes the complexity of obesity prevention and management," says Dr. Arya Sharma, Medical Director of the AHS Obesity Initiative. Sharma is also the founder of the Canadian Obesity Network and is recognized internationally for his research and treatment of bariatric patients.

The Montreal Network for stroke

Research funds allowed the expansion of a network called the Montreal Network for Stroke (RMAVC). The RMAVC now has three Communities of Practice: Prevention, Acute Care and Rehabilitation. These communities consist of over 40 clinicians representing 15 organizations in the health care system associated with the University of Montreal and at McGill University. This project aims to facilitate the activities of knowledge transfer between the active members of RMAVC and those on the periphery of this network. With the website, you can work together to better support patients, you are closer to your colleagues without even moving, you are sure to update your knowledge and more. The website can be accessed at <http://www.rmavc.ca/>, and is in French, but the Communities of practice are intended for both English and French-speaking practitioners. It is supported by the Canadian Institutes of Public Research, University of Montreal, McGill University, Centre for Interdisciplinary Research in Rehabilitation in Montreal and the Institute for Rehabilitation, Gingras-Lindsay-de-Montreal.



National Stroke Nursing Council

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We want your Stroke Nursing News!

Send stories, photos and ideas for content to Colleen Taralson, Editor at Colleen.taralson@albertahealthservices.ca

Teri Green, co-chair of the NSNC and Alberta Representative, is also the new editor of the Canadian Journal of Neuroscience Nursing. Send your research articles for publication to

greenl@ucalgary.ca

The NSNC is on the Web!

See us at:

www.canadianstrokestrategy.ca
and
www.canadianstrokenetwork.ca



Penny in happier times! She missed the conference, instead spending the time in Audrey's lost luggage. ☺

About the National Stroke Nursing Council

The National Stroke Nursing Council was established in late 2005 with the support of the Canadian Stroke Network to promote leadership, communication, advocacy, education and nursing research in the field of stroke.

The Council works to build understanding of the critical role of Canadian stroke nurses, to give a voice to experiences on the frontline and to support the vision of the Canadian Stroke Strategy.

Statement of Purpose

To promote leadership, communication, advocacy, education and nursing research in the field of stroke.

Goals

1. To build an understanding of the critical role of stroke nurses in Canada.
2. To give voice to experiences of stroke nurses on the front line.
3. To support the vision of the Canadian Stroke Strategy.

Objectives

- Build a nationally recognized accessible stroke nursing network
- Disseminate information and best practice standards to stroke nurses
- Facilitate implementation of stroke best practices across the continuum of care
- Promote the value and understanding of the various nursing roles in stroke care

National Stroke Nursing Council Reps from Coast to Coast

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