

This booklet is a guide for those who have had a stroke and their families. It cannot replace the advice of your doctor and multi-disciplinary team. All information is accurate at the time of printing.

The authors also recommend "*The Stroke and Aphasia Handbook*" which offers a comprehensive guide to stroke and the communication disability aphasia and is a resource for everyone with stroke and aphasia, their family members and carers as well as health care professionals (details provided at the back of this publication).

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Introduction

Having a stroke can be one of the most distressing experiences that can happen to anyone. For the family, especially for the person who is left mainly in charge, it can be a bewildering situation with uncertainty about what is happening and what the future holds. Few people know what a stroke is until it affects them or someone in their family. Knowing about the condition may reduce this anxiety.

This booklet aims to improve understanding of what a stroke is, what causes it, how it affects the individual and what you can expect during the period of recovery. As the care of stroke involves many disciplines, we have explained the roles of the various health professionals who are involved in caring for people who have had strokes. This is important, as while multi-disciplinary care should lead to a better outcome for you, it also means that you may have a lot more people to deal with. We offer advice on how the person can be motivated and helped towards recovery. Finally, we cover specific issues such as driving after suffering a stroke.

If you or someone close to you has had a stroke, we hope that this booklet will be helpful. However, it cannot replace the advice of the doctor and the team who are looking after a person who has had a stroke. Please make sure that you ask as many questions as you want - this guide may help you in making up a list of questions.

For family members and carers: This book is predominantly aimed at the person with stroke but family, friends and carers play a huge role in helping recovery after stroke. Sections which relate specifically to family and carers are outlined in red boxes like this one. However, it is probably helpful that people with stroke and their family and carers read all sections that seem relevant to them.

Making sense of the hospital process

While the problems many people experience following a stroke can be straightforward, some people with complex strokes will need treatment from a very wide range of professionals. Your General Practitioner (GP) may make the initial diagnosis and refer you to the Accident and Emergency (A & E) department, where a specialist team will see you. If the stroke is complex, you will normally be admitted to a ward under a consultant physician and be treated by a wide range of professionals.

Most people with stroke in hospital will be under the direct care of a doctor, often a geriatrician, but more often a general physician. Sometimes it will be neurologist. People who have had very severe strokes under the age of 65 may be referred to a rehabilitation physician.

A person who has had a complex severe stroke may not be conscious enough to give permission for the various treatments and procedures they need. As a result, the immediate next-of-kin may be put in a situation where they have to try to understand both the immediate and long-term decisions involving a very wide range of hospital staff.

Most people with stroke over the age of 65 will either come under the care of a specialist in geriatric medicine or receive advice from them. When the critical phase is over and you no longer need to be in an acute hospital (hospital that admits people with chest pain and stroke), if you are under age 65 but have a severe disability you may be referred to a rehabilitation physician.

In time, most people with stroke return home with the support of their GP and community care team. You will then have review appointments at hospital whenever you or the hospital requests them.

Understanding the effects of a stroke can be difficult. An added burden is in trying to understand the health care system which can often be very complicated. Some people who have had a stroke need treatments from a very wide range of specialists in the medical, nursing and therapy professions. Therefore, it is not surprising that those who have had strokes and their families need a lot of time to take in essential information about the immediate effects of the stroke and the long-term treatment programmes.

What is a stroke?

A stroke is caused by an interruption of the blood supply to part of the brain. The term 'stroke' comes from the fact that it usually happens without any warning, 'striking' the person from out of the blue. Although 'stroke' is the most correct term for the illness, you may sometimes hear it referred to as a cerebrovascular accident (CVA). A stroke is not a heart attack.

How common are strokes?

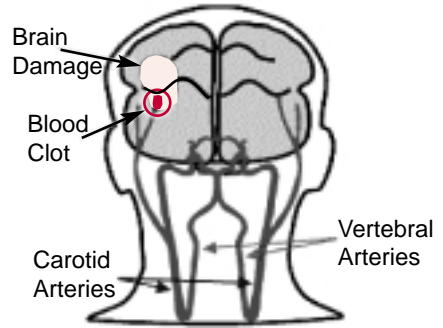
Worldwide, every year 2 in every 1,000 people have a stroke. Five out of six strokes happen in people over the age of 60.

What causes a stroke?

A stroke is caused either by a blockage of an artery supplying blood to the brain (cerebral thrombosis) or a bleed into the brain from a burst blood vessel (cerebral haemorrhage). The most common cause of a stroke is cerebral thrombosis. This happens when a clot forms in a blood vessel (an artery) supplying blood to an area of the brain. Clots form in arteries that have already been narrowed by a condition called atherosclerosis (hardening of the arteries). Atherosclerosis is the main cause of death in the western world today. The two main ways in which it causes death are by affecting the arteries supplying the heart, which causes a heart attack (coronary thrombosis) or by affecting the arteries supplying the brain, which causes a stroke (cerebral thrombosis). Atherosclerosis causes fatty material to build up along the inner lining of arteries so that they become narrower and the blood flowing through them becomes more likely to clot. When a clot completely blocks a blood vessel, this is known as a thrombosis.

Sometimes a partial clot may form in the heart or in the blood vessels of the neck. If this clot becomes loose it may break off and get carried in the bloodstream to the brain where it may get lodged in an artery and block the flow of blood. This type of travelling clot is called an embolism. It is not possible to say by examining a person who has had a stroke whether it has been caused by a haemorrhage, a thrombus or an embolism. Special investigations such as a brain scan (CAT scan and/or MRI scan) and perhaps a heart scan (Echo scan) are needed. Cerebral haemorrhage causes the more serious kind of stroke. Fortunately only about 15% of strokes are caused in this way.

High blood pressure is the major factor that puts people at risk of suffering a stroke due to cerebral haemorrhage.



What is a TIA?

TIA stands for transient ischaemic attack. It refers to the sudden and brief disturbance (usually only for a few minutes) of any of the many functions of the brain. A TIA may cause brief loss of vision, loss of speech or weakness of one side of the body. You will usually recover within a few minutes and you won't have any obvious disability.

TIA's are caused by small clots. A large clot causes a stroke. A TIA is very serious as it is a warning that unless you take action, you may suffer more TIA's or even a full blown stroke. 10% of people with a TIA will have a stroke within a week and nearly 20% within a month. If you get urgent medical attention, this may lower the likelihood of this happening. 50% of people who suffer TIA's will have a full stroke within five years. However, many people who have had a TIA will never have a stroke because they will take notice of the warnings and get medical advice immediately. Some people are not so lucky and have a stroke without having had any warning TIA's.

Why does a stroke happen?

It is not often obvious why someone should have suffered a stroke. Contrary to popular belief, stress, either long term or following a sudden event, is not in itself a cause of a stroke. We do know about certain risk factors that put you at risk of suffering a stroke. The most common is getting older. Other factors are high blood pressure (hypertension), smoking, being overweight, having too much sugar in your blood (diabetes) and having too much cholesterol in your blood (hypercholesterolaemia). During a hospital stay following a stroke, investigations will be carried out to work out if any of these risk factors are present. If they are, you will be given advice on the most appropriate management, for example, losing weight, stopping smoking, keeping as fit as possible and using drug therapy if necessary.

Is there a risk of another stroke?

People do not often suffer from repeated strokes. However, you are more likely to suffer another stroke in the first year. Less often, people may suffer another stroke more than a year after the first stroke. As time goes on, the risk of suffering another stroke will reduce considerably.

You can reduce the risk of having another stroke by following the doctor's advice - stop smoking, lose weight, keep as active as possible and take medication regularly as prescribed. While emotional stress will not lead to another stroke, it may predispose you to smoking or over-eating, and it is worth trying to address the causes of your emotional stress with your doctor or other healthcare professional.

Is there any treatment for a stroke?

The most effective treatment for a stroke is to be treated by a stroke service. This is a hospital service, usually under the care of a geriatrician, neurologist or rehabilitation physician who works with a team of nurses and therapists who deal only with people who have had a stroke. This service is available in a limited number of Irish hospitals. If you are in a hospital without this service and are worried, you can always ask for an opinion from one of the specialists listed above. The stroke service specialises in:

- targeting medical care early for the specific type of stroke;
- fully assessing the stroke; and
- providing a preventive plan against further strokes.

Drug treatment in the early hours after a stroke may benefit certain people. Aspirin is used if you have had a stroke caused by a cerebral thrombosis, but has a limited effect on recovering after the stroke. A newer treatment (thrombolysis or clot busting) aims to dissolve the blood clot with powerful blood thinners. This treatment has been licensed in Ireland and the European Union since 2003. However, it carries a risk of brain haemorrhage if given to certain people, so it must be carefully targeted at only those most likely to benefit. Some of the main requirements for this type of treatment are a full assessment (including brain scan) within three hours of the start of symptoms.

As thrombolysis therapy has only recently been approved, acute stroke medical teams, which provide it, are currently being set up in hospitals in Ireland and Europe. Even when these services are fully up and running most people who have had a stroke will not

be eligible for this treatment. You should not feel disappointed if you, or someone you care for, has not had this treatment.

However, there are a range of lifestyle changes and medications to help reduce the likelihood of your having a further stroke. These include stopping smoking (for which you may be helped by taking nicotine replacement products), exercise (if this is realistic) and controlling your blood pressure. For many people who have had a stroke caused by a cerebral thrombosis, the doctor may decide that taking aspirin once a day may reduce the risk of further stroke. Similarly, for many individuals who have had a stroke caused by a cerebral embolism, the doctor may prescribe drugs called anticoagulants, (the most commonly prescribed one is warfarin), to reduce the risk of a further embolism causing a stroke. Most people with a stroke due to cerebral thrombosis will be started on a medication which lowers cholesterol, and many will be given a medication to lower blood pressure with a tablet called an ACE-inhibitor.

Will I recover?

Recovery is usually a gradual process following stroke, and can often take many months as the brain needs time to heal.

The recovery varies from person to person, and ranges from those who are left with a slight disability to those with a more serious disability. In general, most recovery is made in the first six months, but individuals can continue to make progress after this time.

What are the results of a stroke?

The effects of stroke vary widely depending on what part of your brain has been injured and how much brain tissue is involved. Even minor injury to certain areas can be serious, while other areas can be quite badly injured with little visible effect.

The following effects are particularly common:

Hemiplegia means 'half paralysis' This happens in about 80% of people who have had a stroke. The paralysis, on one side of the body, can be either partial or complete depending on how serious the stroke was. The paralysis happens because there is injury to that area of the brain which sends messages to the muscles in the arms and legs. Sometimes this loss of power affects not only the arm and the leg but also the side of the face. This can result in one side of the face drooping, with drooling from the side of the mouth. Due to the structure of the brain, if the right half of the brain is injured the paralysis affects the left side of the body. If the left half of the brain is injured, the paralysis is on the right side. Balance may also be affected so that you are likely to fall or lean sideways in the bed or chair.

Loss of sensation on one side of the body. This can be more than just loss of feeling in the skin. It can mean that, without looking, you will not know where an arm or leg is positioned. In the most severe cases, this loss of sensation can result in complete neglect of one side of the body. This sensory disturbance can also lead to difficulties with you knowing right from left and your judgement of depth and distance.

Loss of vision. This affects half of the field of vision - nothing can be seen to one side of a central vertical line. If you have a weakness of the left side of your body you may find it difficult to see objects on the left side of the visual field. Often you are unaware of this visual problem and may be surprised to keep bumping into furniture and door frames, for example, on the affected side.

Difficulties in communication. The two major problems are a), a problem in communication caused by not being able to understand the spoken word and, b) a problem in communication caused by not being able to express words. Some people after a stroke have difficulty expressing words or may even lose the ability to speak completely, while at the same time still being able to understand what is being said to them. Never assume that because the person cannot speak that they cannot understand.

Others after a stroke may have difficulty understanding what is being said to them almost as though everyone else is using a foreign language. After a stroke, a person may still be able to speak, but what they say will not always make sense. Reading and writing abilities may also be affected in a person with speech difficulties.

Swallowing difficulties can follow a stroke. Liquids are more difficult to swallow than solid food. This difficulty may cause fits of choking and coughing when you try to drink liquids. If you find it difficult to swallow, you will be placed on a drip and given nothing to take by mouth during the early stages of the stroke. As

the swallowing mechanism recovers you will be advised on special textures of diet by the speech and language therapist.

Loss of intellectual or thinking ability. Loss of intellectual or thinking ability may follow a stroke and the person may have difficulty with attention, concentration, working out problems and grasping new information. If the person complains of memory difficulties it is usually for day to day events rather than long-term memory.

Emotional changes. Experiencing a stroke can be very distressing and the person may experience a range of emotional changes and reactions. These emotional changes are often an expected response to a significant and upsetting life event. Sometimes emotional changes in the person are due to changes in the brain as a result of the stroke. These can lead to the person experiencing little or no control over their emotional responses. For example the person may laugh or cry out of context and for no apparent reason. This is often described as pathological laughter or crying. This can be very distressing for the person and their carers but fortunately is usually responsive to medication.

The role of the rehabilitation team

General practitioner (GP)

Your GP will usually be the first doctor to see you after a stroke. He or she will often be able to diagnose a stroke immediately. He or she will usually suggest that you go into hospital for further investigations, specialised nursing care and rehabilitation. Less frequently, your GP may have the option of arranging therapy at home or on a day care basis in the local hospital.

Hospital doctor

When you go into hospital you will be examined by a doctor and come under the care of a specialist doctor, the consultant. The consultant has overall charge of your care while you are in hospital and works with both non-consultant hospital doctors and the other members of the multi-disciplinary team. As the leader of the care process, you will need to establish your own relationship with the specialist and his/her team. Special investigations are needed to rule out any other illnesses, which may have similar symptoms to a stroke. The doctor will be better able to answer your questions when the examination and investigations are complete. You (and your family if you wish) can and should discuss your diagnosis and treatment plan with the consultant or a member of the medical team.

Hospital nurse

Nurses have an important role to play as they are with you 24 hours a day. They will act as a key link, helping to plan and co-

ordinate the various parts of your care. The nurse will assess you and talk to your family, relative, friend or carer. This is to give us a clear understanding of what your lifestyle was like before your stroke. The nurse will work closely with the other members of the team and encourage you to practise any exercises or tasks your therapists have recommended. They will also help to co-ordinate the advice that you have received from your therapists on how to manage your daily activities like washing and dressing, eating and drinking and moving about. An individual plan will be drawn up that will include oral hygiene, eye care and skin care. The nurse can also provide support and education for you and your carer.

Bladder and bowel control. It is quite common to find that you cannot control your bladder or bowel movements after a stroke. The nurse will assess your incontinence and form a plan just for you to help you regain your continence. Most people become fully in control again in a few weeks.

Preventing complications. If you have been severely affected by the stroke, you may need:

- elastic stockings to prevent deep vein thrombosis
- special equipment such as a hoist to make sure you are moved safely
- a special mattress designed to prevent pressure sores
- an assessment of your seating needs

Finally, the nurse will help to plan your discharge together with you, your family, carers and the multidisciplinary team.

When you leave hospital, the public health nurse will assess you in your own home. This initial assessment will see how often you need visits by the public health nurse and arrangements can be made to refer you to day centres or activity centres if needed.

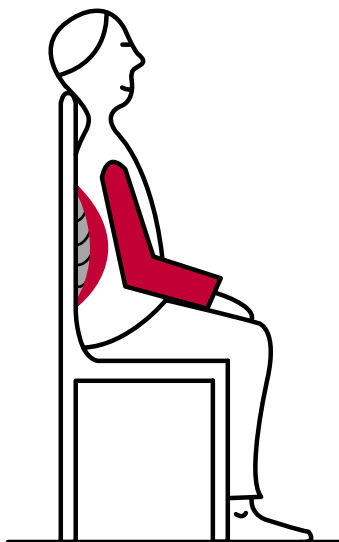
Physiotherapist

The physiotherapist helps you with your physical recovery. The ultimate goal is for you to achieve the fullest movement. However, how much you achieve depends on many issues such as the site and severity of the damage after your stroke.

From the start of your stroke, the affected side, including your trunk (chest, stomach and back) can be weak and heavy, and you may not be able to move these areas. Assessment and treatment planning is vital. The physiotherapist will set realistic goals with you as success depends on your efforts as well as those of the physiotherapist, and your family. The physiotherapist will review and reset your goals if this is necessary. Getting into good positions is important (in lying and sitting) to support the weak side and to reduce as far as possible the changes in muscle caused by inactivity and altered muscle tone. The physiotherapist can show you the correct positions to use to support the weak limbs and trunk.

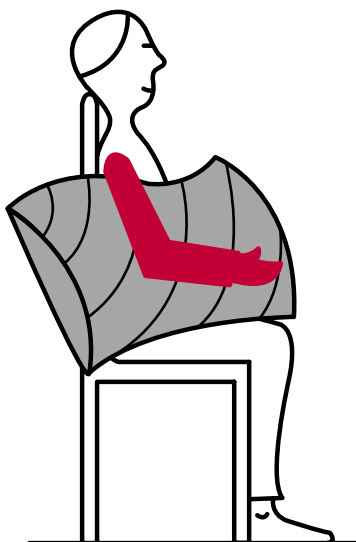
The diagrams on the following pages provide details of the correct positions to use when sitting and lying down.

SITTING



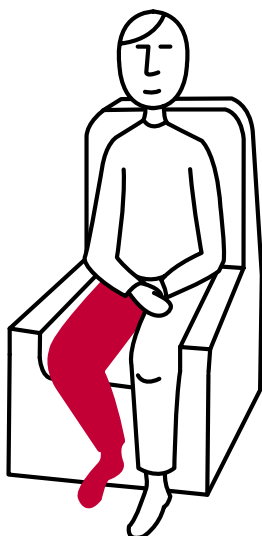
LUMBAR (BACK) SUPPORT

To help with maintaining upright posture use a pillow or roll for back support to help maintain a good sitting position.



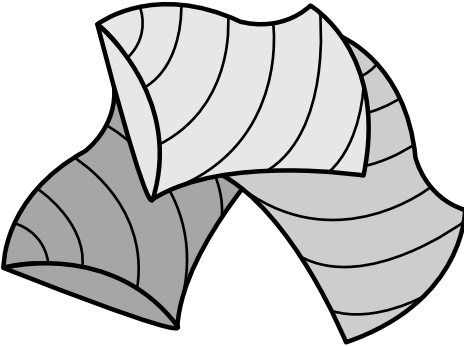
PILLOW SUPPORTING WEAK ARM

Place a pillow underneath the weak arm as near to the shoulder as possible to give support. Pillows may be placed under both arms if more comfortable or supportive.

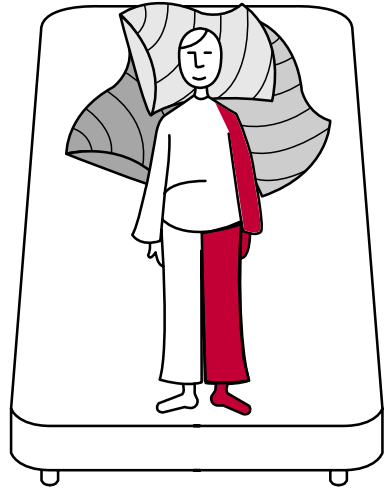


If the weak leg is falling sideways and the foot is not flat on the floor, placing a folded pillow or towel inside the armrest of the chair will keep the weak leg in a neutral position and the weak foot flat on the floor.

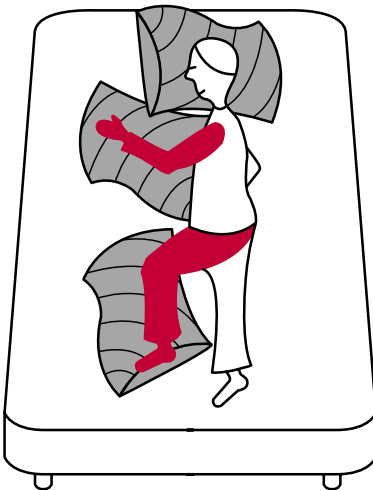
LYING



Three pillows crossed supporting head and shoulders down to waist.



Lying on your back. Pillows crossed as illustrated. Pillows should support the shoulders and down to the waist. Head in mid-line position.



Lying on unaffected side, weak arm as straight as possible on pillow, arm supported from shoulder to hand, fingers and thumb as straight as possible.

Weak leg supported on a pillow with the knee slightly bent, do not place anything against the sole of the foot.

At first, the physiotherapist will concentrate on achieving sitting and standing balance. After a stroke your weak side is floppy and then can become stiff which makes the muscles short and inflexible. Early treatment aims to make your muscle tone normal and work towards achieving normal movement in sitting and standing, working on both sides of the body. Two physiotherapists may work together to help you to stand at first. When one side of the body is weak, the other side may become overactive. This over-activity often blocks movement of the weak side and movement of your trunk. This can help both sides of your body to work better and so improve your balance. Balance involves both sides of the body. If the (so-called) good side is working too much, it blocks the weak side from working. This is often a big problem when working on balance.

Good balance is the ability to transfer weight from one side of the body to the other side in sitting and standing. You may begin walking when you have some standing balance and movement in your weak leg. You may use a walking stick or frame at the appropriate time to help you walk. The ability to walk is complicated and may be difficult to achieve. As a result you need to be aware of this and try not to get too frustrated. A walking stick or frame does not compensate for standing balance but it takes some weight off your weak limb, which makes it easier to walk. You may get an individual exercise programme to help your muscles work as well as possible.

The physiotherapist always includes family members in the treatment programme and advises on caring for your weak shoulder.

If shoulder pain occurs in your weak arm, you should seek advice from your physiotherapist as soon as possible.

The physiotherapist will also show your carer and family member how to move you to avoid anybody getting hurt (for example, the carer getting back pain or you damaging your weak shoulder).

When you leave hospital, physiotherapy may continue either at home or at the hospital as outpatient physiotherapy or in a day hospital. All members of the multidisciplinary team work together during the rehabilitation phase.

General advice

- Moving about should not be uncomfortable for you or the person helping you
- Your weak shoulder is prone to injury if it is pulled strongly and should be supported by pillows when you are sitting and sometimes when you are lying down
- Regular exercise as recommended by the physiotherapist, is essential to maintain good movement in your joints and muscles
- The physiotherapist can give your carers advice about helping you

Occupational therapist (OT)

The occupational therapist works to help you become as independent as possible in your activities of daily life, leisure activities, working, driving and socialising to the best level possible.

A stroke may affect people in different ways depending on the area of the brain involved. It can affect you not just physically but your speech, your concentration, your ability to judge or reason things, or it may affect the way you make sense of the information you receive from your senses.

At first the occupational therapist may start by assessing your activities of daily living (washing dressing etc.) physical abilities and your cognition (concentration, memory, or judgment and reasoning skills).

Cognition involves the ability to organise objects and events. It also includes the ability to use information with your memory and stored knowledge, to try and correct actions and behaviour in response to changes in the environment.

Following a stroke you may (but not always) have difficulties with your attention or your ability to remember information. Or you may have problems learning how to do things, making decisions, following instructions or finding the solutions to problems.

Perception involves the ability to process information from the senses, being able to organise this information in association with past or present experiences. Following a stroke there are a number of perceptual problems that can happen. Some are more common than others. For example after a stroke you may appear to forget or not pay attention to things on your left-hand side, or mix up how to put clothes on or how to do other everyday things.

If you are having difficulties in any of these areas, the occupational therapist will put together a treatment programme to look into ways in which any of these difficulties may be preventing you resuming the life you led before the stroke.

The treatment programme aims to work on the difficulties you are having as identified from the OT's assessments. Before you can resume your daily living activities such as showering, dressing, washing your hair, or making your meals, you not only need the physical abilities such as adequate balance, and being able to reach or get things, but you also need to keep your attention, to remember how to use or hold things and make sense of the information you are receiving from your eyes, ears and touch.

The occupational therapist will often work closely with other therapists and members of the team to work on any difficulties you are having. This may involve working with the physiotherapist or the speech and language therapist to help you to resume your life again as much as possible.

You should ask how you can continue practising these techniques or for ways of carrying out daily living activities at weekends or in the evenings.

Sometimes, due to the severity of the stroke and the areas of the brain affected, you may need to use adaptive devices to help you eat, wash yourself, prepare food or dress. The occupational therapist will assess what adaptive devices you need and provide them.

Before you leave hospital, the occupational therapist may carry out a 'home visit'. This involves a visit home with the hospital or community occupational therapist and often another member of the team (physiotherapist or medical social worker). The purpose of this visit is to assess what equipment or alterations to the home might help you resume your daily life as safely and independently as possible. It can also give the team information on the correct timing of when you go home or your ability to return home at the weekend.

These alterations may involve adjusting the height of armchairs or providing a second rail on the stairs, a handrail beside the toilet or bath or shower. The hospital-based occupational therapist will often then work with their colleague in the community, the community occupational therapist, who will arrange for this equipment and alterations to take place.

Sometimes after a stroke people may experience difficulties reading, this may happen for a number of reasons and it is important to contact your occupational therapist if you think this is happening.

- Family members and carers form an important part of the team. So if you have any questions about any of the items mentioned, please contact your occupational therapist.
- You should take time with the person to allow them time to make decisions.
- You should also encourage them to make decisions for themselves for example, what clothes to wear and what they want to do.

Speech and language therapist (SLT)

The speech and language therapist has two roles in caring for you. They: assess, diagnose and treat swallowing difficulties; and assess, diagnose and treat communication difficulties.

Dysphagia

Dysphagia is the medical term for difficulties swallowing. Due to brain damage caused by a stroke, eating and drinking may be difficult, as the muscles of chewing and swallowing are weakened especially in the early stages. It is common to have a feeding tube in the early stages either through the nose (nasogastric tube (NG tube)) or through the abdomen (percutaneous endoscopic gastrostomy (PEG tube)). These tubes can be easily removed if/when the dysphagia resolves. The SLT may x-ray your throat to see what your swallowing difficulties are and what types of food and drink are safe for you to eat. This x-ray is called a videofluoroscopy. The SLT may also provide special swallowing therapy to help you swallow safely.

Communication difficulties

There are a number of ways in which your communication may be affected after a stroke. How severe these disorders are vary from person to person and may change over time. It is also possible to have more than one of these communication disorders at the same time. A sudden change in the ability to communicate may have a devastating effect on the person, especially at a time when communication seems so important, for example, asking questions, taking in information, conveying fears and anxieties. Try to be patient and work with the SLT on how best to help with communication.

We have listed some of the terms used by the speech and language therapist to describe communication difficulties after stroke.

Aphasia

Aphasia (also referred to as dysphasia) is a disorder that affects your ability to understand and use language. People with aphasia **can** think clearly, but they have difficulty getting their message **in** and **out**. Aphasia takes many different forms. It may be characterised by total or partial loss of understanding words, speaking, reading or writing. There are a wide variety of symptoms of aphasia which vary from person to person. Some common features include:

- mixing up yes and no;
- saying one word while meaning another for example, 'brother' for 'sister';
- getting stuck on one word or phrase over and over again;
- understanding only headlines in the newspaper;
- following only parts of conversations;
- being easily distracted by noise, and other people's conversation;
- automatic swearing;
- slow responses, taking time to process what is heard;
- being able to recite the days of the week but being unable to say what day today is;
- words on the tip of the tongue;
- speaking fluently but not making much sense (jargon) or using words that sound foreign or nonsensical.

Problems with understanding words and sentences

Although you can hear words, you may have difficulty making sense of them. It can seem as if everyone is speaking a foreign language that cannot be understood. This can vary from not understanding any spoken words to having difficulty if someone is speaking too quickly, is using complicated instructions or if there is background noise.

Problems with expressing thoughts and ideas in words and sentences

Here you may have some degree of difficulty putting what you want to say into words. You may have problems putting a complete sentence together or being unable to find the right words. Some people produce 'jargon', which is fluent but empty or meaningless speech.

Problems with reading or writing

You may have difficulties recognising written words or understanding the meaning of what you have read. You may also have trouble with spelling or putting words together to write a complete sentence.

Dysarthria

This is the name given to a group of disorders, which affect movement of the muscles involved in producing speech including the lips, tongue, soft palate, and vocal folds. Weakness, slowness, or poor co-ordination of movements will result in slow, slurred or nasal - sounding speech, which may be difficult to understand. It is often accompanied by difficulties with swallowing.

Apraxia of speech

Apraxia is a disorder which results in difficulties putting speech sounds together correctly. Its severity varies from being unable to put any meaningful words together to slightly 'foreign' sounding speech. It rarely happens on its own, there is usually an element of aphasia.

Right-hemisphere damage

Certain communication problems may arise following a stroke to the right side of the brain. Some of these may include difficulty understanding what people mean by what they say, in other words, understanding the intention behind a conversation for example, understanding sarcasm, humour and irony. People with right-hemisphere communication problems may have difficulty following conversational rules for example, they may 'butt in' and interrupt inappropriately when someone else is speaking. They may also have problems changing their voice to match their emotions.

Things that help with communication - tips for the communication partner

- Use all types of communication, such as speech, writing, drawing, gesture and pointing
- Allow plenty of time for a response
- Keep talking naturally as you would to any other person
- Reduce as far as possible, background noise such as TV or radio
- Keep your sentences short and uncomplicated
- Repeat important words and write them down to clarify meaning
- Introduce one idea at a time, using short straightforward sentences

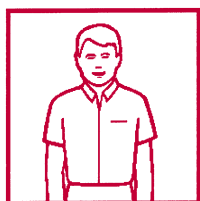
Communication devices

In some cases communication aids can be helpful. These can be as low tech as a picture or alphabet chart or as high-tech as a computer. How useful these aids are will depend on your needs and abilities as determined by the SLT.

Therapy

Speech and language therapy may take many different forms at different stages in the rehabilitation process. The amount of speech and language therapy you receive will depend on many factors, for example, the services offered by the clinic or hospital, transport and so on. Generally when you are still in hospital you may be seen more often than when you have returned home. More therapy does not always mean more improvement. Speak to your SLT if you have any concerns about this.

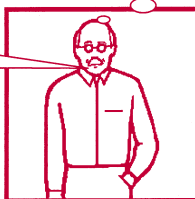
Very often people know what they want to say but just can't say it correctly.



'Week...after this holiday sun'

I am going on holiday to Spain next week.

'Today, today, ehm, today'



I've missed my doctor's appointment.

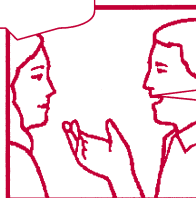
'I deed due dues sues sues shoes'

I need new shoes



Fine thanks

How are you?



'A du du du du'

Clinical nutritionist and dietitian

The nutritionist or dietitian will assess your nutritional status. They will make sure that your dietary needs are met by assessing your nutritional requirements, monitoring what food you eat and educating you on the type of food and drink most appropriate for your needs. Where necessary, they will advise you on how to correct or prevent dietary problems. Their aim is to promote and maintain your health through accurate and practical advice and written information.

We can divide the role of the dietitian into three areas:

Preventing disease

As mentioned previously, certain conditions will increase the risk of developing a stroke. Many of these are diet-related. The dietitian will give you advice on how to manage these conditions. They will also give you practical tips on maintaining a healthy lifestyle.

Management of nutrition after stroke

Weight changes often happen after a stroke. It is crucial to monitor this and to be a healthy weight. Some people gain a lot of weight because they are not as active as they would like to be, or tend to eat more. Other people lose a lot of weight because they eat a lot less. This can be due to not being able to eat enough at mealtimes, poor appetite or low mood and taste changes. It is important to deal with these problems quickly to speed up your recovery and help to build up your immune system.

Eating enough calories and protein is important to make sure that your weight is stable and to prevent pressure sores. You may need to add energy to your meals or take extra snacks and drinks. Sometimes, the dietitian will recommend special supplementary drinks and puddings for you to make sure you are having enough calories.

Swallowing problems are very common after a stroke. Your speech and language therapist will have recommended a specific type of diet for you, usually altering the consistency of your food and drink. The dietitian will make sure that what you are taking is enough to meet your nutritional needs.

Sometimes you may not be able to swallow safely. You may need to receive some or all of your nutrition through a feeding tube. You may still be able to eat and drink with a feeding tube if your speech and language therapist feels it is safe to do so. Most people only need a feeding tube for a short length of time.

Management of your nutrition when you leave hospital

Looking after your diet when you leave hospital is vital. A healthy balanced diet may help to prevent you from having another stroke. If you have diabetes, high cholesterol or high blood pressure, remember to follow your diet plan. If you have lost a lot of weight, it is important to reach a healthy stable weight.

Practical tips

- Be a healthy weight
- Eat a balanced diet with a variety of foods
- Prevent constipation! Take plenty of fibre-rich foods.

Most of these will suit all texture needs. Go for cereals like weetabix and porridge. Fruit and vegetables will also add variety, colour and taste to meals

- Drinking enough is important. If you don't like water, juice or milk, remember that jelly, soup and sauces count as fluid too
- If you are watching your weight, choose low-fat foods - lean meat and low-fat milk, cheese and yoghurt. Low-fat spreads have less fat than butter or margarine
- If you need to gain weight, add butter to potatoes, vegetables, sauces and savoury food. It is high in calories but won't fill you up. Grated cheese will add extra flavour as well as energy
- Add sugar, honey or jam to desserts and porridge
- If you have to change the texture of your diet, add extra calories and protein. Cream and milk in soups, sauces, porridge and mashed potatoes are good suggestions for extra calories.
- If you need more advice on your diet, ask your GP or hospital consultant to refer you to a dietitian.

Medical social worker

The medical social worker helps you and your family with the psychological and emotional aspects of illness.

After your stroke, the aims of social work are to:

- support you and your family;
- provide counselling to you and your family to deal with the emotional implications of the stroke;

- provide a link between you, your family and the multi-disciplinary team;
- help with family meetings;
- help with all aspects of future planning
- provide the practical advice and help you need in areas such as finances, employment, housing and care of other family members; and
- help with appropriate referrals to community services.

Clinical psychologist

Psychology is the study of behaviour. Clinical psychology is the study of people's behaviour following a clinical event, like a stroke. For people who have had a stroke, the clinical psychologist is mainly interested in two areas:

- How you are functioning in relation to your thinking (cognitive) skills, for example, attention, memory and reasoning
- How you are adjusting to a significant change in your day-to-day and future life.

If you are referred to a clinical psychologist, they will investigate specific aspects of your cognitive functioning. By understanding what is the precise nature of the problem, it may be possible to develop a strategy to reduce the effect of the problem. Clinical psychologists are also asked to see people following a stroke because you or your carers may be distressed by the changes that result from the stroke.

The assessment carried out by clinical psychologists usually involves interviews with you and others who can provide relevant information. Psychological tests can provide helpful information on the nature of the problems you may have after a stroke. These findings are usually discussed with other members of the multidisciplinary team in order to have a full picture of the changes you are experiencing following the stroke. Unfortunately there are currently very few clinical psychologists dedicated to the speciality of stroke care. However, we hope that this will improve in the future and as a priority at least be available in stroke units/services and all specialised services caring for people who have had a stroke.

Role of relatives

People who have suffered a severe stroke can make a significant recovery. Family and friends play a crucial role in supporting and encouraging the person during the different stages of recovery. The natural response for many carers and relatives is to be protective, but sometimes this can interfere with the person having the opportunity to practise their skills as prescribed by the clinical team. The role of relatives and carers is to strike a balance between being protective and encouraging independence – the best way to achieve this is with continuous communication with the person with the stroke and the clinical team.

Allowing the person to do things for themselves may take longer and require patience. However, it is time well spent as it will help to rebuild the person's self-confidence – a vital factor in the rehabilitation process.

Even a person who has experienced a severe stroke can continue to lead a satisfying life provided that they learn to adapt to their new physical limitations. Here the role of family and friends is of vital importance in coping with the months and years ahead.

Support services in the community

Your family doctor (GP) should be aware of all the services that are available to people who have had strokes and their families. You can use these services immediately if you do not go into hospital. Or, they can be arranged beforehand when you are due to leave hospital. The following are some of the services available:

Public health nurse (PHN)

The public health nurse provides a range of services to do with every aspect and stage of life. They will provide useful advice on managing difficulties that can arise in providing basic care for a person after stroke in the home. When you are ready to leave hospital, the liaison nurse will act as a link between the hospital and community nursing service. You or your carer may contact the local health centre. The public health nurse will assess your needs so they can provide appropriate support services. The public health nurse is part of the community care team. They can refer you to the occupational therapist, speech and language therapist, physiotherapist, community welfare officer, social worker, chiropodist, home help service and community dietician. They can also provide or advise on practical aids (suitable beds,

backrests, cushions, incontinence wear and commodes). They will provide or arrange personal care or nursing care if you need it. They can answer questions like ‘How can I make life easier from day to day around the house?’

Talking to your public health nurse can prevent a worry from becoming a problem.

Community therapists

Access to community physiotherapists and occupational therapists for treatment at home is limited, particularly outside towns and built up areas. In some areas private therapists are available. Speech therapy is currently not available in the person’s home.

In general, the availability of social services in the community for people with stroke and their families has been limited. The development of community care teams in some towns is a welcome initiative.

The community care team

The community care team is made up of a number of professionals including a nurse, care assistant, physiotherapist and occupational therapist, and in some areas a speech and language therapist. The hospital or family doctor may ask the team to provide a limited period (usually 12 weeks) of intensive care within the home. The aim of the community care team is to

provide as much help as possible in the first few weeks after you have had the stroke or left hospital.

At the end of this time, the team will withdraw and you and your family will be expected to have reached a level of independence and to be able to provide care without a great deal of outside help. However, the services of the public health nurse will continue to be available. For some individuals, a day hospital may be a more suitable alternative to the community care team.

Day hospital

Day hospitals are usually in the grounds of a general hospital. They are under the supervision of consultant doctors who specialise in caring for older people.

Day hospitals provide services for individuals who are well enough to live at home but who continue to need either regular medical supervision or the services of the hospital physiotherapist or occupational therapist. A social worker is also available for advice at the day hospital. Most day hospitals provide transport to and from the hospital with a minibus or ambulance collecting you and bringing you home.

When you leave hospital, arrangements may be made for you to go to the day hospital if this is necessary. If you are at home, the family doctor can arrange for the local consultant to assess you to decide whether you would benefit from going to the day hospital. This assessment is usually carried out in the outpatient department of the hospital.

You will normally go to the day hospital for a limited period of rehabilitation. A day hospital is not the same as a day centre.

Day centre

Day centres do not provide medical care and they usually do not offer rehabilitation services. However, they provide important social care such as bingo and dances. There are day centres in many community centres. Your GP, public health nurse or social worker will be able to make arrangements for you to go to the day centre. Some centres provide transport if necessary.

Stroke clubs

In a number of areas there are stroke clubs, which act as social centres for people who have had a stroke. Usually they meet about once a month. The emphasis is on social activities with outings arranged throughout the year. These clubs are run on a voluntary basis and have been a valuable development in stroke rehabilitation.

Emotional issues after a stroke

How any of us cope with major life events is complex, very individual and dependent on a number of variables, in particular how we previously coped with stress and the quality of the supports available to us for example, emotional, financial and social supports. Following a stroke, you may have a considerable range of feelings for example, a sense of loss and redundancy, rejection, self-doubt and anger. It takes time, information about the nature and prognosis of the stroke and the support of loved ones, to begin to grapple with the longer-term effects of the stroke and how they might affect your day to day life and the ability to interact as you did prior to the stroke. Similar to other significant life events, a stroke can herald a time for personal reflection and re-evaluation. This can certainly be a very constructive time allowing you and your carers to look at the priorities in your life and your goals for the future.

With some kinds of stroke the particular part of the brain that is affected may interfere with your ability to recognise your problems, for example you may not 'see' that you have problems with thinking or perception. This lack of recognition is not a deliberate action to deny or repress problems but is a sign of specific cognitive changes in the brain that interferes with your ability to identify and evaluate your difficulties. Fortunately this problem usually resolves over time.

Knowing how best to support loved ones who are experiencing emotional problems following their stroke requires careful consideration of each person's particular

needs as well as time, communication and liaison with the clinical team. A good understanding of the nature of the stroke and its likely prognosis can help allay fears and uncertainties about the future. Trying to help the person resume as many activities as they had prior to the stroke can be reassuring and if adaptations need to be made, making sure these happen in a timely and efficient way. A helpful psychological approach is to work with people's strengths and to minimise any weaknesses. If this is undertaken in a context of support and encouragement, feelings of anxiety and depression are less likely to escalate. Opportunities for respite should be encouraged because living with longer -term illness can be very debilitating for all concerned - acknowledging this is central to effective coping.

Emotional 'lability'

Following a stroke many people cry very easily, often without feeling particularly sad. This inappropriate emotional response is a sign of injury to brain function. It can be distressing for you as well as for your carer. It helps if the cause is explained.

Drawing the person's attention elsewhere often helps to stop the display of emotion.

Sex after a stroke

Sex is an important and very normal part of the lives of most people of all ages. It involves both physical and emotional

feelings, sexual attitudes, sexual behaviour and emotional intimacy. It is a personal issue that will mean different things to different people. As individuals we vary widely in terms of how we express our sexuality and the kind of sexual relationships we have. In close relationships, sex can be very positive, giving physical satisfaction and promoting emotional closeness and self-esteem.

Sex is a sensitive subject and one that is often difficult to talk to others about. Following a stroke it is normal to have questions about the possible effect on sexual relationships.

As the person who has suffered a stroke you may worry that changes in feeling or movement on one side of your body will affect your ability to enjoy sex. You may be worried that your appearance has changed and that you are less attractive to your partner. You may have difficulty speaking which is affecting communication and closeness with your partner. You might feel generally low and not be really interested in sex at all. You or your partner might be worried that having sex might be harmful or cause another stroke. You might be embarrassed to discuss your feelings with your partner or health professionals and avoid sex altogether.

The good news is that the ability to have sex is rarely damaged by a stroke and it is unlikely that having sex will cause another stroke. However, returning to a satisfying sexual relationship may take time and involve some changes, depending on how severe your stroke was.

After a stroke it is important that you and your partner have

information and help. The rehabilitation team will hopefully give you or your partner opportunities to talk about any possible effects your stroke may have on your sexual relationships. This may include discussing the medications that you are now taking and if they are likely to affect your sexual ability and desire. Remember it is normal to have questions about sex and it is very important if you have any concerns that you and your partner raise them with members of the rehabilitation team.

Practical aspects of care

Feeding

At home, non-slip mats or plates with suction pads are available which prevent the plate from slipping and make eating with one hand easier. Utensils with thick handles are often easier to use. Cut any meat and so on into bite-sized pieces before you serve it to the person, as cutting the meat when the plate is at the table can make the person feel like a child.

Dressing

The most important point is to give the person plenty of time to get dressed. Arrange the clothes on the bed for them with those to be put on first on top. The occupational therapist will advise on simple procedures that can make dressing easier, for example, when dressing, put the weak arm or leg into the clothes first. When undressing take the good arm or leg out of the clothes first.

At the beginning, loose clothes are excellent, especially tracksuits with wide neck openings. Elasticated waistbands mean the person does not have to fasten any buttons. Zips are easier to manage than buttons. Velcro is the easiest option and can be put into the clothing instead of buttons or zips.

Slip-on shoes, with good grip and support at the back, put on with the aid of a long shoehorn are better than laced-up shoes. However, by the time the person returns home hopefully, they will, in most cases, be able to wear their own clothes.

Washing and bathing

Sitting at a table with a basin of water on a non-slip mat is easier to manage than trying to wash while standing at a sink. You need a good mirror. Electric razors make it easier to shave with one hand.

A free-standing shower is easier to use than a bath. You can sit on a chair in the shower. Special showers are available that allow wheelchair access and you can get financial help from the local authority to have one fitted.

If necessary, the occupational therapist in hospital will tell you about the wide range of bath aids that are available.

Transfers

This refers to your ability to get in and out of chairs and on and off the bed. Transfers can be difficult, even for someone who can walk. Many beds and chairs are too low and too soft to allow you to push off them. The occupational therapist will advise you on suitable chairs and beds. The physiotherapist will advise on the correct transfer technique to help you move. Most importantly, do not let anyone pull your weak arm in case they hurt you, or even dislocate your shoulder.

Standing and walking

Shoes should be comfortable and firm and provide good support. If you need to use a walking frame, your carer may need to rearrange the furniture. If you can walk about the house but cannot do longer distances, you can use a wheelchair for trips outside, for example, to the shops or to church. Again, the occupational therapist will advise you on the correct use and care of a wheelchair.

Stairs can be a big problem, especially if you want to continue to sleep upstairs. A second railing fixed along the wall gives a handhold on both sides. The occupational therapist can arrange for this to be fitted. In the meantime, you may manage by going up and down the stairs sitting on your bottom.

For short flights of stairs, for example at the front door, an outdoor rail or ramp might be fitted. The housing authority can help with this.

As your mobility improves you may need advice from the physiotherapist on: whether it is safe to attempt walking with support from another person, or whether you might benefit from using a mobility aid such as a walking frame, stick or foot support.

The physiotherapist will advise you on their correct use. You should also talk to the physiotherapist if you are considering changing your mobility aid as safety is very important.

Going to the toilet

If the toilet is inaccessible, for example, upstairs, you may need a commode. The public health nurse should be able to provide this. You may have to consider having a toilet downstairs with a wide front-door frame, to allow wheelchair access. You should be able to get money for this from your local authority. Ask your social worker who will advise you. Rails around the toilet and a raised toilet seat can be helpful. The occupational therapist can arrange these for you if you need them. The toilet paper should be within easy reach of your good hand. Sheets of paper are easier to manage than rolls. Easily managed clothing helps a lot.

Bladder function

Some people after a stroke cannot control their bladder. Go to the toilet regularly, for example every two hours or use a urinal (bottle) regularly. Try to pass urine even if you do not have an urge to. This will help to keep your bladder empty and to keep you dry.

Disposable pads which fit neatly and discreetly inside underwear, are very useful. Your public health nurse will supply them. More absorbent pads are available for night-time. It is very rare that you will need a tube (catheter) permanently in your bladder. While you have the catheter, your urine will drain directly into a plastic bag. If your urine starts to smell unpleasant or if you have pain when you pass urine, tell your doctor as you may have a urine infection. It is important to change your pads regularly and to keep dry to reduce the risk of getting pressure sores.

Bowel function

Constipation is a common problem after a stroke and it is uncomfortable. A stroke can also cause incontinence of urine and occasionally be the cause of diarrhoea.

To avoid constipation, you should drink plenty of fluids and eat foods containing fibre, for example wholewheat cereals, brown bread, fresh fruit and vegetables. A tablespoon of bran added to soups and stews can be helpful. You should not use laxatives unless your GP or public health nurse tells you to.

Driving after a stroke

About one third of stroke survivors used to drive before their stroke. Some do not want to continue to drive afterwards but about half of those who are discharged from hospital after a stroke should be able to get back to driving. You should tell the motor vehicle licensing authority and your insurance company

that you have had a stroke. These authorities will need a medical report from a doctor familiar with you, and the disability that the stroke has caused.

There are some situations where the doctor will not allow you to return to driving. One of these is if you have convulsions after a stroke. You may not drive for one year after a seizure, or if you have a particular type of loss of sight called a hemianopia. If you or your family have concerns that your stroke has affected your ability to drive, discuss this with a member of the rehabilitation team. An on-road driving assessment may be arranged for you as a part of this assessment.

If you drive a commercial or public-service vehicle, current Irish regulations are very restrictive for driving after a stroke. Only in exceptional circumstances will you be able to resume commercial or public-service driving, even if you recover enough to start driving a private car. Discuss this with your specialist and team and you may need help in exploring other employment possibilities with your employer

Stressful aspects of caring

After the initial sudden stress of the acute stroke, there is a phase of recovery where there may be rapid improvement. In some cases, the realisation dawns that while you have partly recovered, you may never recover fully. Your husband, wife, partner and the family face the task of coping with a chronic disabling illness.

The major task of providing the physical care, the emotional comfort and moral support needed for recovery usually falls to the spouse, partner or other close family member. The carer's responsibility is a heavy one and nobody should be expected to carry this level of responsibility alone without help or advice.

The stressful aspects of caring can lead to feelings of resentment towards the person with stroke, even anger and then guilt about having these quite natural feelings in these circumstances. Chronic stress can lead to physical symptoms of fatigue (extreme tiredness) and insomnia (not being able to sleep). You should not ignore these signs, as this type of chronic stress can lead to further problems..

It is important you take steps to ease the stress of caring. It is particularly important that you have some time to yourself each week away from the person with stroke. During this time physical exercise such as walking or gardening can help relieve stress. All measures to reduce stress will benefit the carer and the person with stroke, as the carer will be able to continue to care more successfully when they feel refreshed.

If other family members are not able or not willing to give you a break, it can be helpful to contact the voluntary or statutory agencies to ask for the help of a 'sitter' for a few hours each week. The person with stroke may be able to go to a local day centre regularly. Many of these centres offer social activities but also exercise classes, recreational activities and advice on living with disability.

For longer breaks, for example, during the summer holiday season, your GP or social worker will be able to arrange a period of respite care for a week or more in a local hospital or nursing home.

Respite care

Respite care refers to a prearranged stay in a hospital or nursing home. It is usually for a week or two weeks, often during the summer or around Christmas. Some people need regular respite care every few months. Respite care can be arranged by your GP or Public Health Nurse. It is usually planned some weeks in advance, but sometimes emergency respite can be arranged if, for example, your main carer falls ill or needs to go into hospital themselves.

Respite care is an important service and is designed to give the carer a break from the physical and emotional stress of caring.

You can get help, advice, and support from the organisations listed at the back of this guide.

Getting back to work – vocational rehabilitation

Getting back to work is another goal of your rehabilitation but you may find it difficult to access such services without talking to an occupational therapist. A vocational assessment service is available in the National Rehabilitation Hospital, Dublin to people under age 65 who have had a stroke. The aim of this service is to

consider vocational options, working with you, to pinpoint your strengths and weaknesses, skills and experience. Keeping in mind your goals and ambitions, this service explores your options for returning to work, alternative employment options, possible retraining or activity which includes leisure or social activity. Your occupational therapist will deal with any questions you may have about this service.

An alternative route is by way of referral to outside services such as FÁS who offer employment support schemes, workplace and adaptation grants and community employment schemes, or to other training agencies such as the National Training and Development Institute, a branch of Rehab Group <http://www.rehab.ie/ntdi>

Together with the rehabilitation team you should discuss the best way to approach your employer about returning to work, possibly in a phased way. You may need to make some adaptations or changes if your stroke has affected your ability to manage computers or machinery that is relevant to your job. Many workplaces will have an occupational health service which is meant to help you and your workplace to adapt to your present condition. Your family doctor, or the consultant involved with your care, may need to give a report on your current condition (and likely level of recovery) to the doctor who provides the occupational health service to your employer.

Useful addresses:

Irish Society of Chartered Physiotherapists

Royal College of Surgeons in Ireland

121 St Stephen's Green

Dublin 2

Phone: 01 4022148 Fax: 01 402 2160

Website www.iscp.ie

They can give you a list of private physiotherapists who treat people after a stroke as well as leaflets on stroke and physiotherapy.

Association of Occupational Therapists of Ireland (AOTI)

29 Gardiner Place

Dublin 1.

Phone: 01 878 0247

Website: www.aoti.ie

They can give you a list of private occupational therapists who treat people after a stroke as well as leaflets on stroke and occupational therapy

Carers Association

68/71 Great Strand Street

Dublin 1

Phone: 01 288 1781

Website: www.sjog.ie

The Psychological Society of Ireland,

CX House

2A Corn Exchange Place

Poolbeg St

Dublin 1

Phone: 01 474 9160

Website: www.psihq.ie

Irish Association of Speech and Language Therapists (IASLT)

29 Gardiner Place
Dublin 1
Phone: 01 878 0215
Fax: 01 878 0215
Website: www.iaslt.com

Irish Association of Social Workers

114-116 Pearse St
Dublin 2
Phone: 01 6774838
Website: www.iasw.ie
email: iasw@eircom.net

Irish Nutrition and Dietetic Institute (INDI)

Ashgrove House
Kill Avenue
Dun Laoghaire
Co Dublin
Phone: 01 280 4839
Website: www.indi.ie

Irish Heart Foundation

4 Clyde Road
Ballsbridge
Dublin 4
Phone: 01 668 5001 Fax: 01 668 5896
Website: www.irishheart.ie
email: info@irishheart.ie

Volunteer Stroke Scheme (VSS)

249 Crumlin Road
Dublin 12
Phone: 01 455 9036 Fax: 01 455 7013
www.strokescheme.ie

Leaflets on stroke are available from the VSS on 'Stroke Prevention' and 'Stroke - 20 Questions'.

National Disability Authority (NDA)

25 Clyde Road
Ballsbridge
Dublin 4
Phone: 01 668 4181
Website: www.ndi.ie

National Rehabilitation Hospital

Rochestown Avenue
Dun Laoghaire
Co Dublin
Phone: 01 235 5000 Fax: 285 1053
Website: www.nrh.ie

Irish Wheelchair Association (IWA)

John Sullivan Resource Centre
Ballinagappa Road
Clane
Co. Kildare
Tel: 045 861346
Website: www.iwa.com

Tony Regan,

Transport and Mobility Consultant
19 Glenmalure Pines
Glenmalure Golf Club
Greenane
Rathdrum
Co. Wicklow
Phone: 0404 43854 Mobile: 087 263 5025
email: tonyregan@ireland.com

BRÍ

C/O The National Rehabilitation Hospital
Rochestown Avenue
Dun Laoghaire.
Co Dublin
email - briassoc@eircom.net

Headway

Headway has offices in Dublin, Cork, Kerry and Limerick.
Phone: 1890 200 278
Website: www.headwayireland.ie

National Training & Development Institution (NTDI)

A branch of the Rehab Group www.rehab.ie/ntdi

Other useful websites

European Stroke Council:

www.eurostrokecouncil.org

American Stroke Association:

www.strokeassociation.org

Internet Stroke Centre at Washington University St Louis

www.strokecenter.org

Council on Stroke, Irish Heart Foundation

www.irishheart.ie

British Association of Stroke Physicians:

www.basp.ac.uk

The Stroke Association:

www.stroke.org.uk

Different Strokes:

www.differentstrokes.co.uk

Aphasia websites

Aphasia Help UK

www.aphasiahelp.org

Speakability UK

www.speakability.org.uk

Connect UK

www.ukconnect.org

Queensland University Aphasia Groups Australia

www.shrs.uq.edu.au/cdaru/aphasiagroups/index.html

The Stroke and Aphasia handbook was created by the charity 'Connect'. Available from Connect by telephone or email:

Telephone: 0044 20 7367 0848. Website: www.ukconnect.org

Glossary of terms

- Agnosia - An inability to recognise familiar objects using a given sense. However, there is no damage to the corresponding sense organ. Someone with visual agnosia may fail to recognise a hairbrush using their sight only but may identify it correctly through touch.
- Aphasia - a disorder of language which may affect understanding, speaking, reading and writing words and sentences to varying degrees.
- Apraxia of speech - a motor speech disorder as a result of a reduced ability to programme the movements needed for speech but where the muscle structure is not weak or paralysed.
- Aspiration: When food or drink go into the larynx and enter the airway causing choking.
- Associated reactions - This is a reaction of muscles not under voluntary control. They may happen when a person tries a difficult task or is upset. For example, when dressing the upper body the lower leg may straighten out.
- Ataxia - A tremor when a person tries to move his or her affected limbs. It may involve the trunk causing unsteadiness when standing and walking.
- Dysarthria - a motor speech disorder as a result of weakness or incoordination of the muscles involved in speech.
- Dyslexia - a problem with the ability to read.
- Dysgraphia - a problem with the ability to spell.
- Dysphagia - the medical term for difficulties swallowing.

- **Dyspraxia and Apraxia** - the loss of ability to perform a previously known movement despite having all the motor power, sensation and co-ordination to do the action. It is a problem of sequencing or of initiation.
- **Figure ground** - Difficulty telling the difference between the foreground and the background - in other words, finding your toothbrush among all the items in the background of all the items in your wash bag.
- **Flaccid** - reduced tone. A very limp and heavy arm is known as flaccid. The arm will not move.
- **Form constancy** - Difficulty recognising everyday objects when viewed from unusual angles, in unusual positions or when they are of different sizes but of similar design.
- **Hemianopia** - Loss of some of your visual field, normally on the same side as the affected limbs. Part of what your eyes see is lost. Functional difficulties are often related to safety concerns such as crossing the road, negotiating stairs and so on.
- **Hemiplegia** - A one-sided paralysis. The paralysis is usually on the side of the body opposite the side of the brain damaged by the stroke. A face, arm, leg or the entire side of a body may be affected.
- **Hemiparesis** - A one-sided weakness only again it can be a leg, arm, face or the entire side of body.
- **Labile** - showing uncharacteristic emotion, for example, crying or laughing at inappropriate times.

- Muscle tone - Normal muscle tone allows freedom of movement without conscious thought. Tone needs to be high enough to support the body and allow it to move. If tone becomes too high, it can affect movement. Emotion, pain and effort and also different postures and positions can affect tone.
- Neglect - hemineglect is characterised by lack or decrease of attention to stimuli and events on the left hand side of the patient following a right sided stroke.
- Parasthaesia - Experiences of pain, numbness or odd sensations of tingling or prickling in paralysed or weakened limbs.
- Perception - the process by which we make sense of what we see (visual perception), what we hear (auditory perception), and what we touch (tactile perception). The messages from the senses such as the eyes going back to the brain are not been dealt with properly.
- Proprioception - Sensory awareness of the position of your body in space in other words where your arms, legs and so on are as you move and rest.
- Videofluoroscopy - a radiographic study performed by the SLT to view the motor sequence of swallowing with precision and accuracy.

Stroke, a guide for those affected by stroke and their carers is an Irish Heart Foundation patient information publication. Other titles in this series are:

- Step by step through cardiac catheterisation and angioplasty
- Things you should know about Blood Pressure
- Things you should know about Heart Surgery
- Heart Attacks
- Living well with Heart Failure
- Step by Step through Angina
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