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Qualitative Study of Stroke Related Communication between Primary and Secondary Healthcare Professionals

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Introduction

The number of people who have had a stroke is rising. In England, the National Institute for Health and Care Excellence (NICE) stroke guidelines urge that anyone who has had a suspected or confirmed stroke be admitted to a specialist stroke facility to receive the necessary treatment as soon as possible. Stroke rehabilitation follows, which is a comprehensive rehabilitation team giving support and treatment to stroke survivors. The shift from acute to rehabilitation settings for stroke survivors might take place in the hospital, at home, or in the community. Early Supported Discharge (ESD) is a form of treatment that provides community-based health and social care as an alternative to inpatient care. NICE recommends that all relevant health and social care information be included in transfers of care from hospital to community, and that it be communicated to relevant health and social care workers and patients as soon as possible. Long-term care provided by community generalists is advised, and stroke survivors are encouraged to self-refer if they have any problems. However, it is uncertain whether primary care models of treatment are helpful in meeting the unmet requirements of stroke survivors and caregivers, and implementing integrated care remains a difficulty. In a 2017 National Audit, for example, ESD was only offered to 34.6% of eligible patients. Early discharge services for people (including stroke) lower hospital lengths of stay, according to Cochrane reviews, but they have no effect on mortality overall.

Integrated care models are becoming more popular, in which different yet connected institutions such as health and social care providers and organizations interact. Beyond ESD, however, integrated stroke care remains underdeveloped in the UK and around the world, with patients and careers describing follow-up care as fragmented. As part of satisfying survivors' and careers' needs for continuous support, integrated stroke care services necessitate good information flow between healthcare specialists after discharge. Multidisciplinary teams, including community-based services and specialty acute stroke and rehabilitation services, work together in integrated care models. Integration of generalist and specialist services is particularly difficult because it needs diverse sectors to agree to share not just specific methods and financial arrangements, but also values and goals among a wide group of practitioners from many disciplines. Many stroke survivors have ongoing physical and mental health needs (e.g., speech, mobility, and emotional difficulties) that require input from stroke specialists and generalist clinicians. Stroke is a good exemplar condition in which to explore these issues because many stroke survivors have ongoing physical and mental health needs (e.g., speech, mobility, and emotional difficulties) that require input from stroke specialists and generalist clinicians. Because over half of stroke patients report unmet requirements up to five years after their stroke, existing integration is likely inadequate.

Stroke survivors and caregivers report insufficient follow-up from healthcare personnel, as well as poor communication and continuity of treatment between healthcare services. This is linked to a lack of knowledge of each other's jobs and time constraints among healthcare practitioners. In the long run, patients report having unfulfilled needs and feeling unsupported. High-quality care transfers are marked by good communication, but it's unclear how much timely and correct information is transferred from the hospital to the community for stroke survivors. Phone conversations, case conferences, and care planning meetings are some of the ways generalists and specialists communicate about stroke management. Communication mechanisms and quality between generalists and specialists throughout the transition from hospital to home are still poorly understood.

Generalists and Specialists have Overlapping Roles

Depending on a patient's clinical and social needs, healthcare workers reported varied degrees of engagement in stroke survivors' care. In acute care settings, specialists acknowledged their role in triaging patients' rehabilitation requirements, making referrals, and producing discharge summaries and letters, for example. Patients may then be discharged to an ESD (intensive support for up to six weeks and stroke reviews, *i.e.,* a structured review of the patient's health status, medications, cardiovascular events, and hospitalization), a stroke outreach service, a stroke rabblement service, other acute services, or directly to a GP. Some doctors claimed to be able to provide assessments and recommendations to other agencies.

In particular, some GPs reported referring patients to community neuro rehabilitation programmers in the absence of an acute care specialist referral or other indicated needs, while others claimed they were unaware of the expert facilities to which they may refer patients. All GPs said they check on stroke survivors on a regular basis, including assessing their medication, blood pressure, and emotional state. Nurses in primary care have also been reported to conduct reviews of stroke survivors' needs (by themselves, GPs, and ESD staff). The length of time between generalist reviews varied, with some reporting six weeks and others reporting six months. Participants said they concentrated on physical concerns and rehabilitation, as well as encouraging patients to seek assistance on their own. Participants, on the other hand, admitted that their connection with patients had spanned multiple time periods. The majority of participants emphasized striking a balance between comprehensive care and time-limited consultations by having open discussions about patient's health and wellbeing, taking into account the complexity of patients post-stroke condition, and conducting/requesting necessary clinical investigations.

Several studies have looked into the communication procedures of generalist and specialized care providers in the United Kingdom, as well as the hurdles and enablers to this. These studies usually focus on the viewpoints of patients and caregivers, as well as healthcare

workers on rare occasions. Understanding and respecting professional responsibilities and functions is a fundamental skill and support and value mechanism underpinning inter professional collaboration, according to previous studies. Some participants viewed GP surgeries in particular as long-standing support mechanisms for stroke management. Specialists (for example, therapists) identify their roles as having a defined end point and are thus temporally limited. As a result, all involved in the care route must agree on role limits in order to manage expectations. After a stroke, patients have unmet long-term requirements that might be addressed in general practice. Despite some stroke survivors (e.g., those in care homes) being more passive actors in the management of their care, generalists acknowledged relying on stroke patients to reveal their needs. Furthermore, our data indicate that different levels of understanding of responsibilities and service duties exist, which obstructs inter professional communication. This disparity in knowledge between generalists and specialists suggests a lack of organizational infrastructure or support for joint communication, which could be due to disparities in how healthcare personnel and services are funded in England. Understanding the care routes, roles of team members, and areas of overlap is critical for supporting prompt information exchange, collaborative working, rehabilitation plan preparation, and long-term care provision. As a result, generalists and specialists must have a thorough understanding of responsibilities and services. Current stroke guidelines in the United Kingdom urge inter professional teamwork so that patients can be sent to suitable treatments as soon as possible. Despite the fact that following clinical standards could improve patient care and outcomes, a systematic assessment of healthcare professionals' adherence to stroke-specific recommendations revealed variable adherence, which was based on the generality or specificity of the guidelines. Our findings reveal that generalists and specialists have limited time for inter professional communication and are challenged by the lack of a common vocabulary or terminology, limiting their ability to communicate.

Despite knowing the importance of well-coordinated transitions between stroke care phases, study participants reported obstacles to putting guidelines into practice, such as limited involvement in a patient's care due to the need to discharge from one care environment to another, and the lack of fluid information transfer due to changes in team or service structures. Our findings, which are consistent with previous studies, suggest that efforts to improve adherence to stroke recommendations in primary-secondary care settings are needed to address variations in treatment delivery. Furthermore, policymakers should be aware of the complicated care pathways that healthcare professionals navigate and factor them into decisions on integrated care. Inter professional collaboration requires effective communication. Primary-secondary care communication can be aided by technology (e.g., email). These tools, however, appear to be inconsistently available among providers and geographical areas in this study. Participants suggested shared information systems as a solution to bridge the communication gap between experts and generalists, despite the fact that numerous routes of contact were recognized. There is some evidence that shared information systems can improve information exchange and care coordination among healthcare personnel, notably in the case of stroke. Standardized templates or evaluation tools for recording patient data can also help with communication amongst providers. Participants in the study, however, stressed that these should be built in such a way that different providers can understand how to utilize them so that high-quality data can be exchanged. All of the survey participants praised the importance of having solid inter professional relationships that allow for open and free communication.