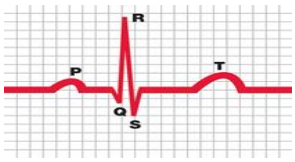
SSNF Newsletter –Autumn 2016, Conference Edition

Welcome to the Scottish Stroke Nurses Forum Conference!

'The Stroke Beat'

Practice, Quality, Research in STroke



Hello from the SSNF Chair Campbell Chalmers

The conference 'The Stroke Beat' explores the current issues in relation to practice, quality and research in stroke. Thank you to all the speakers and in particular our keynote speaker Prof. Keith Muir, University of Glasgow, presenting on 'Neuro-Vascular Care after Stroke'.
The conference marks the end of our current 'Strategy for Stroke Nursing in Scotland 2011-2016'. The strategy had three main focuses:

1. Improve the quality of nursing care and support the implementation of evidence based practice.
2. Have a key role in the development of stroke educational resources for nurses and in raising awareness and uptake of these resources.
3. Contribute to stroke nursing research to develop the evidence base; and promote awareness and implementation of research findings.

Today we have an interactive session to seek your assistance with developing our next SSNF strategy.

This newsletter also has a number of articles about nursing activity to inspire you. We encourage you to network with colleagues, visit the exhibition stands and join the poster tour over lunchtime.

The SSNF has its own Facebook and Twitter pages; and at today's conference we have our Twitter wall up and running. We'd like to post your thoughts, experiences, photos and selfies throughout the day.

The SSNF membership has increased steadily over the past year to a landmark 550 members today. If you know of anyone who may be interested in joining the SSNF please encourage them to do so. We actively seek to involve members in the work of the forum; particularly those working in clinical areas. If you are interested in getting more involved please attend today's annual general meeting (AGM).

Enjoy the day! Campbell, Chair of the Scottish Stroke Nurses Forum

Stroke Association Fellowship Awards

Have you considered a Postgraduate Fellowship to enable you to obtain a postgraduate research qualification (MPhil or PhD) and using the opportunity to improve your research skills.

The Stroke Association Fellowship Awards are open to Nurses and you have until Wednesday the 2nd November 2016 to get your application in.

The fellowships are awarded to named candidates who can demonstrate excellence in stroke research. Is that you? If you are interested you can access more information and the application forms by going to:

https://www.stroke.org.uk/news/call-postdoctoral-fellowship-applications-now-open

https://www.stroke.org.uk/news/call-postgraduate-fellowship-applications-now-open

Remember one of the aims of the SSNF is to: To incorporate research-based evidence into practice and promote research to improve outcomes. By being a member you can request access to the SSNF membership to participate in your research projects. You could also start your own research study based on one or more of the Life after Stroke Top Ten nursing research priorities commissioned by the SSNF in 2015.

Table 1: Top ten nursing research priorities

1	What are the best ways to manage and/or prevent fatigue?
2	What are the best ways to improve cognition after stroke?
3	What are the best ways to manage urinary and faecal incontinence?
4	What are the best ways to manage altered mood and emotion after stroke?
5	What are the best ways to promote self-management and self-help after stroke?
6	What are the best ways of helping stroke survivors and their families come to terms with uncertainty of prognosis and the long term consequences of stroke?
7	Can a goal setting approach help recovery after stroke?
8	What is the impact of thrombolysis on emotion, cognition, and communication?
9	Is a 'young stroke environment' better than other stroke rehabilitation environments at improving recovery of young people after stroke?
10	What is the optimal amount and intensity of therapy provided by nurses for patients with stroke?

Alice's Story

The following article was written by Charlie Chung PhD, Stroke Specialist Occupational Therapist at the Queen Margaret Hospital in Dunfermline. It was published earlier this year in the OT news and it is with Charlie's permission that we have reproduced it for the SSNF Newsletter. He explains how a short-term investment in a three agency, occupational therapy and physiotherapy partnership,

has made long term gains.

Occupational therapists are often presented with the dilemma of when to continue rehabilitation and when to discontinue services for people who have experienced a stroke.

This is the story of Alice, who had a stroke, needed two home carers, four times a day, and who made significant gains from private neurological physiotherapy, outreach stroke occupational therapy and community rehabilitation.

Her story addresses several different themes including the effective ingredients of a home-based rehabilitation programme, partnerships between the health and private agencies, and of Alice and her partner Stephen.

The potential for these combined services to be cost-effective also emerged as a theme when the rehabilitation enabled Alice to reduce the number of carers required to assist her.

BackGround

Following a stroke in June 2012, Alice spent periods in the acute stroke unit and several months in a rehabilitation unit, from where she was discharged. Her abilities at the time were limited to being able to eat once set up but she required assistance with all other activities of living.

In the summer of 2014 my team and I worked with Alice in the day hospital for ongoing rehabilitation but made little progress during these periods and she continued to require the assistance of two home carers at home to move from bed, chair, toilet and shower. In August 2014, Alice was discharged from the day hospital with a professional consensus that she was at her optimum level of function. I scheduled a review at six months to evaluate the home-based self-practice programme.


Alice and Stephen

Provided Services

Stephen remained convinced that Alice still had the potential for further recovery, despite professional opinion suggesting the opposite. In September 2014, Alice's functional level remained unchanged when she and Stephen employed a private physiotherapist, Virginia Kelly (Ginny), from a neurological rehabilitation company. There were soon improvements in Alice's posture, sit-to-stand and transfer ability, which were maintained by working with the home carers. Alice was then able to take a few steps with assistance, using a walking frame, for the first time. In January 2015, the community rehabilitation team became involved following contact from Stephen and Ginny, as it was apparent that progress was being achieved that justified the input of NHS services.

I commenced day hospital outreach sessions following the six month review. It quickly became apparent that Alice was continuing to progress as a result of both therapy in-put and self -practice between sessions. Alice and Stephen were able to work on sitting to standing with a walking frame during activities of daily living and Stephen and I established self-practice set-up on the kitchen table, for daily practise of gripping and releasing household objects. I also introduced electrical stimulation to facilitate the practise of digit extension particularly her index finger, which she constantly maintained in full flexion.

Recovery

By June 2015, significant progress had been achieved in relation to Alice's occupational performance and she was able to reach, grip and retrieve all her practice objects. She was able to pick up her drinking mug by the handle with adequate co-ordination and dexterity of her index finger. She was able to put on a cardigan without assistance. Work was ongoing with the community rehabilitation team, which consisted of OT Margaret Malcolm and physiotherapist Gary Muir, and Alice was undertaking transfers and walking several steps with the minimal assistance of one person, when she had required two carers for the previous two years. This allowed her to use the toilet and walk out of the bathroom, before sitting in her wheelchair. In addition, work commenced to increase her ability to transfer in and out of the family car. From requiring two home carers four times a day, Alice's care package was reduced to one home carer at each visit.

To explain why Alice achieved such an improvement in her functional ability two and half years after her stroke, it is important to address a number of questions around how this recovery came about, and consider what we can learn to allow others to realise their occupational performance potential. What were the effective ingredients that contributed to Alice's increased independence?

The right time?

Therapy at home provided possibilities not available in the day hospital. Alice had difficulty engaging in therapy due to poor sustained attention and difficulties remaining alert. When Ginny commenced the home-based sessions following day hospital discharge, progress was made as Alice could engage more effectively. It may have been fortunate timing that Alice's alertness improved as home-based therapy commenced, but it is likely that Ginny's bed-based postural work and home carer education enabled Alice to see her posture improve to engage more effectively and maintain alertness. This was probably more a question of therapy being delivered in the right place rather than being a question of timing.

The right place?

Alice made limited progress in the day hospital. The day hospital that Alice attended delivers a full programme and many patients make significant progress. However, the process of attending the day hospital may have contributed to her fatigue. This involved an early rise and an attendance of over five hours. The difference in Alice at home was notable. She had more energy and appeared more empowered to state her preferences. There were additional benefits from the home-based therapy delivery. Although home programmes are an integral part of the day hospital service delivery, it is often a challenge for people to put these into practice. This may be due to carers with little experience having difficulty setting up a written programme at home.

We worked with Alice to establish a therapy programme using furniture and objects within the home to provide frequent practise opportunities. The agreed goals related to occupational performance within the home, for example walking in and out of the toilet with the walking frame, and getting in and out of the car, and household objects were used for upper limb training which were permanently set up on the kitchen table.

Complementary elements from inter-service team working

Our services brought complementary aspects to the programme. Ginny provided a neurorehabilitation speciality to the posture, transfer and mobility interventions. Margaret and Gary provided a community speciality involving the application of techniques to improve independence with sit to stand and using the walking frame for transferring and walking. This was aimed at increasing occupational performance participation in using the toilet, moving around the house and transferring in and out of the car. I provided a stroke specialist focus and worked with Alice on improving hand grip patterns for her selected occupations of dressing, eating and drinking.

Therapy intensity

Although our three services were involved, Alice received only two sessions a week and the self-practice between sessions may have been an important factor contributing to Alice's progress. If we accept that an adequate number and duration of sessions is required to influence recovery, service delivery should aim at providing this dosage which included self-practise. In the current climate, where healthcare resources are extremely stretched, the design and implementation of well-designed, self-practised programmes are essential for occupational therapists to work towards delivering of adequate intensity.

An instrumental partnership

Our partnership, consisting of Alice and Stephen and specialist occupational therapy and neurological physiotherapy, appears to have been instrumental in Alice's improved occupational performance. My sessions are now complete but OTs Margaret and Jean Izatt continue to visit, to work with Alice to reach her optimum level of occupational performance. Alice is now washing dishes while standing at the sink using both hands, is using the telephone and is in the process of discontinuing her use of her wheelchair at home. Alice's story provides an example of how a person can recover a greater level of independence, even at three years post stroke and it is important to provide a programme with therapy with the right composition, in the right place.

Where therapy resources are limited it is essential to optimise therapy through creative mean, including self-practice with skilled set-up in the home. If the person-centred outcome can also result in the reduction of the level of support required, a strong argument can be made that a short-term input of occupational therapy can lead to financial savings from decreased packages.

If you would like more information please contact: Charlie Chung PhD Tel: 01383623623 Ext 23532

With a very special thank-you to Alice and Stephen for allowing us to share their very personal experience of how stroke has affected their lives and their belief that there is always scope for improvement.

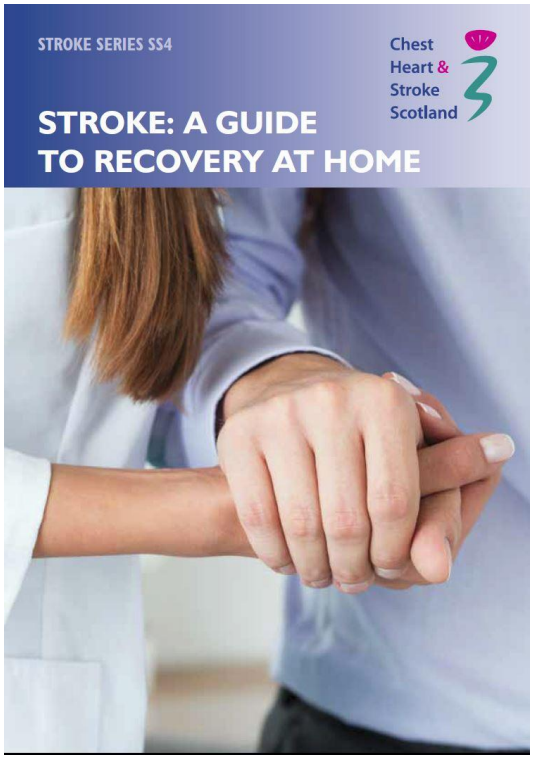
Alice and Stephen, 2016

Chest Heart and Stroke Scotland New Information Booklets

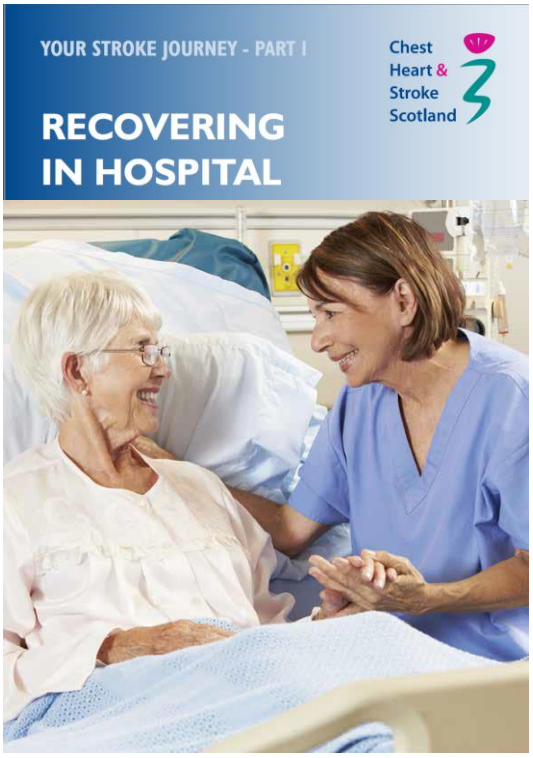
Chest Heart and Stroke Scotland has recently published two new stroke information booklets for people who have had a stroke. They replace the previous booklets Stroke: A guide to recovery and You've had a stroke.

Stroke: A guide to recovery in hospital (SS1) explains how to recognise a stroke, what a stroke is and what happens after a stroke from emergency care through to beginning recovery and rehabilitation in hospital and planning to return home. It aims to answer the immediate questions and worries a stroke patient and their family might have in the first few days and weeks after a stroke.

Stroke: A guide to recovery at home (SS4) covers what to expect in the longer term as recovery continues and provides information on how to manage recovery after returning home. It also provides some practical advice on what support is available to help people as they cope with life after a stroke.



To complement these booklets, CHSS has also produced two aphasia-friendly stroke journey booklets, specifically written for people with communication difficulties after a stroke. These booklets are written in a clear and easy to understand format with pictures and symbols summarising concepts and explanations of stroke and its management. The booklets are broken down into two parts: **Your stroke journey: Recovering in hospital, and Your stroke journey: Recovering at home.**



All of these booklets are available free of charge from CHSS. Orders can be made by email: publications@chss.org.uk, tel: 0131 225 6963 or online at www.chss.org.uk

Can you help us? We would welcome any comments or feedback you might have on these resources so that we can continue to develop high quality information that is accessible to as many people as possible. Also if you would be willing to review any future publications for us, please do get in contact with our health information team at healthinformation@chss.org.uk

INSsPiRE: International Network of Stroke secondary Prevention Researchers

In December 2015, Maggie Lawrence hosted a meeting of fourteen UK and EU researchers, clinicians and academics with an interest in stroke secondary prevention of stroke, at GCU London. The main outcome of the meeting was that we are now established as a group INSsPiRE). INSsPiRE includes researchers, clinicians and academics, from a range of healthcare professions, who have an active research interest in stroke secondary prevention, and specifically in trials of behavioural/behaviour change interventions.

The group agreed to look for funding to develop a **Consensus Statement on Outcomes and Outcomes Measures for use in Stroke Secondary Prevention (behavioural) research**. The consensus statement will make recommendations about which outcomes to measure and what tools to use to report those outcomes. The need for this important work was identified following publication of three stroke secondary prevention systematic reviews, led by Maggie (see references below). The reviews **revealed a lack of high quality evidence** with which to inform **clinical practice** in secondary prevention and subsequently **improve outcomes for stroke survivors and families**. This lack of evidence is partly due to inconsistency in the choice of outcomes and outcome measures.

The hope is that by developing and publishing the consensus statement we will establish INSsPiRe as an important member of the global stroke research community. This will help us to extend our membership and to work collaboratively to improve **health and wellbeing outcomes** for stroke survivors and families around the world.

As you know, for the foreseeable future, stroke is predicted to remain a major cause of mortality and disability, globally. Stroke carries with it a high risk of recurrence, incidence of other cardiovascular events, and mortality. Whilst research efforts continue to reduce the incidence and effects of primary stroke, work on secondary prevention remains a vital, and until recently overlooked and underfunded, part of the journey of stroke recovery. INSsPiRE aims to raise awareness of these issues and to work towards providing **high quality, economically viable, evidence-based** solutions. The group seeks to do this in **collaboration** with third sector organisations and other key stakeholders.

For more information, please contact Maggie: Maggie.lawrence@gcu.ac.uk

Papers

Lawrence M, Pringle J, Kerr S, Booth J. 2016. Stroke survivors' and family members' perspectives of multimodal lifestyle interventions for secondary prevention of stroke and transient ischaemic attack: a qualitative review and meta-aggregation. Disability & Rehabilitation, 38(1):11-21 doi:10.3109/09638288.2015.1031831

Lawrence M, Pringle J, Kerr S, Booth J, Govan L, et al. 2015. Multimodal Secondary Prevention Behavioral Interventions for TIA and Stroke: A Systematic Review and Meta-Analysis. *PLoS ONE* 10(3): e0120902. doi:10.1371/journal.pone.0120902

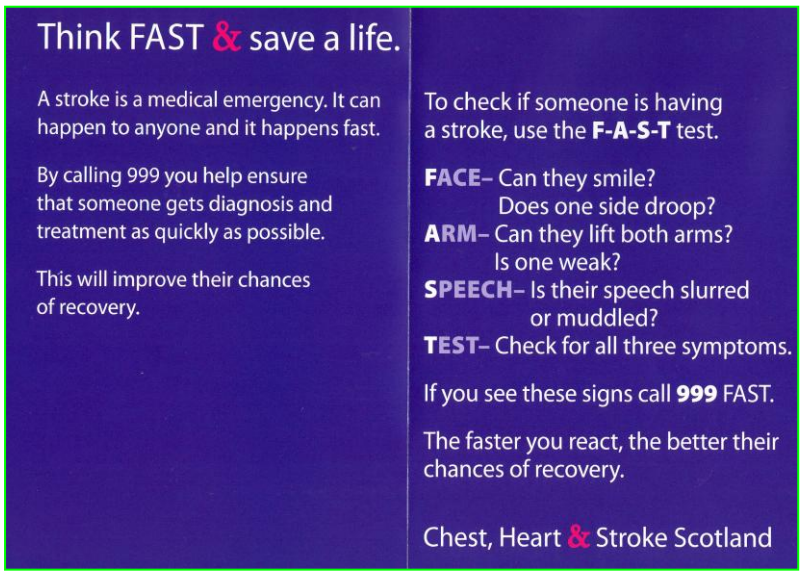
Lawrence M, Booth J, Mercer S, Crawford E. 2013. A systematic review of the benefits of Mindfulness-Based Interventions following transient ischaemic attack and stroke. *International Journal of Stroke*, 8:465-474 doi:10.1111/ijs.12135

Strategy for Stroke Nursing in Scotland

Can you believe that our 5 year strategy is due for renewal? The current 5 year strategy took shape in 2011 and since then the SSNF has grown in strength, numbers and influence thanks to the hard work of all its members and the committee. We have become more inclusive including health care assistants and student nurses into our numbers. Our current membership stands at 545, let's make it 600 for 2017!

The FAST campaign has been one area that the SSNF has focused on. The forum has developed tailored resources for nurses, held targeted workshops and education

sessions, including Stroke and TIA Assessment Training (STAT) across Scotland. This work will continue in the next strategy as raising awareness of stroke symptoms is key to improving outcomes, early investigations, having access to clot busting treatments and secondary prevention. Remember TIME IS BRAIN.

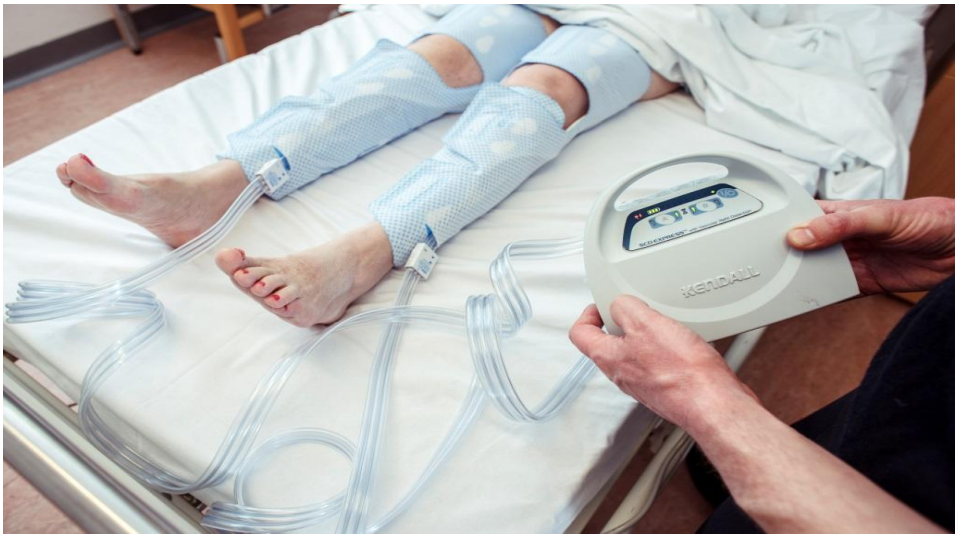


Staffing in Stroke Units is one of the hot topics at the moment and has been part of the last two SSNF Strategy and Work-plans. In 2006 the SSNF completed a Benchmarking Exercise that looked at staffing levels and further work is now going on in conjunction with the National, Welsh and Irish Stroke Nursing Forums to produce a paper that will give minimum staffing levels for the whole of the UK. Some of this work will be presented at the 2016 SSNF Conference so watch this space. This work will without a doubt continue in the next 3 years and the SSNF will continue to lobby and influence this.

Supporting the new stroke standards launched earlier this year and promoting nurses' awareness, in their contribution and achievement to meet the standards is a key achievement of the last 5 years. We have worked with the Scottish Stroke Improvement Team to promote the standards and this includes updates at every meeting, promoting the SSCA Nurse Training days and workshops and an annual update at the SSNF conference to influence practice and stroke nursing involvement. The SSNF will continue to work with the Stroke Improvement Team to improve stroke standards across Scotland.

Many members of the SSNF have been involved in the development, launch and implementation of the Best Practice Statements. These BPS are now due for update and the SSNF will be looking for members to get involved in the updating process. If you would like to be involved or would like more information please get in touch

The SSNF has participated in the development of further Advancing Modules on www.stroketraining.org and promoted the use of the SCoT competencies toolkit. We have also supported developments in patient self management and carer education such as www.Stroke4Carers.org and www.SelfHelp4Stroke.org. If you haven't had a look at these do so they are an excellent learning resource and can enhance your stroke knowledge further. Education leaflets and information on Intermittent Pneumatic Compression for Nurses have also been produced and as we are sure you are aware the use of IPC in the first 30 days after stroke not only prevents DVT but increases the chance of surviving the stroke event.



IPC in use

In April 2015 the Top 10 Stroke Nursing Research Priorities were reached by SSNF members from all of the Health Boards at a consensus meeting held in Glasgow. This research was a collaborative with SSNF, CHSS, NMAHP-RU and Edinburgh Napier University. This information is available on the newly revamped SSNF website on www.ssnf.scot/ and is due to appear in publications later this year. As well as conducting our own research our members have also participated in the research of others, filling in on line surveys, questionnaires and in telephone and face to face interview on topics including; Breaking difficult news, Palliative Care and Nasogastric Feeding. The SSNF would like to encourage more of our members to undertake stroke research. You could use one of the Top 10 topics to get started. Research will continue to feature in the next SSNF Strategy for 2017-2022.

So what are the next steps? At the next SSNF Committee Meeting in November we will be looking forward to the next 5 years and to new challenges that should go into the 2017-2022 strategy. What do you think our priorities should be, what areas should we be championing and most importantly would you like to be part of this? If so get in touch with your local member, send us an email or come along to a committee meeting, we would love to see you and have your input.

If you would like more information please contact: linda.campbell8@nhs.net

NHS Fife **Public Dental Service**

Oral Health Advice following a Stroke.

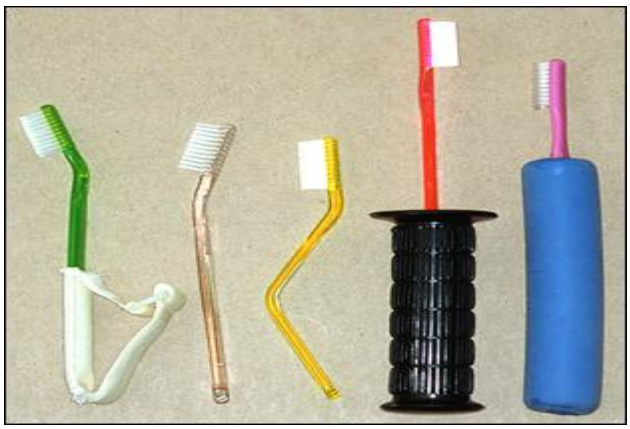
Following a stroke often there are considerable changes to how the mouth and face function. Everyday tasks such as eating and swallowing can be difficult. This can make maintaining good oral hygiene seem daunting. But it is important to look after the teeth to avoid dental problems and keep the mouth comfortable particularly as more people than ever are retaining their natural teeth.

Many of the symptoms experienced after a stroke can increase the risk of tooth decay, gum disease and oral infections e.g. Dysphasia and facial palsy both reduce the rate food is cleared from the mouth. This causes food to be in contact with the teeth for longer increasing the likelihood of tooth decay, especially with modified and thickened foods which can have high sugar content. Oral hygiene is of importance as there is growing evidence of links between poor oral hygiene and aspiration pneumonia.

Some medications prescribed after a stroke such as those for high blood pressure can cause a dry mouth (Xerostomia). Normally saliva lubricates the mouth and has a protective effect. In dry mouth tooth decay can progress rapidly. Dry mouth can also increase the risk of oral infections such as candidiasis (thrush). People with dentures can find a dry mouth makes their denture uncomfortable to wear.

There are a number of toothbrushes with modified grips available for people with dexterity problems. Electric toothbrushes may also be of benefit.

Figure 1 Adapted toothbrushes.



Each individual should seek specific oral health advice from their Dentist.

In general for people with natural teeth tooth-brushing should be carried out at least twice daily with a toothpaste containing at least 1450 parts per million of fluoride. This will be indicated on the ingredient list. Where dysphagia is present teeth should be brushed in an upright position with a dry soft toothbrush with aspiration available if required. There are also several non-foaming toothpastes on the market which reduce aspiration risk. Dentists advise not rinsing out after brushing; "Spit don't Rinse !" as this allows your toothpaste time to work. When a person has no natural teeth the mouth should still be cleaned twice daily, with a small soft tooth brush, such as a baby brush. Dentures either full or partial should be cleaned twice daily as advised by the dentist and removed at night.

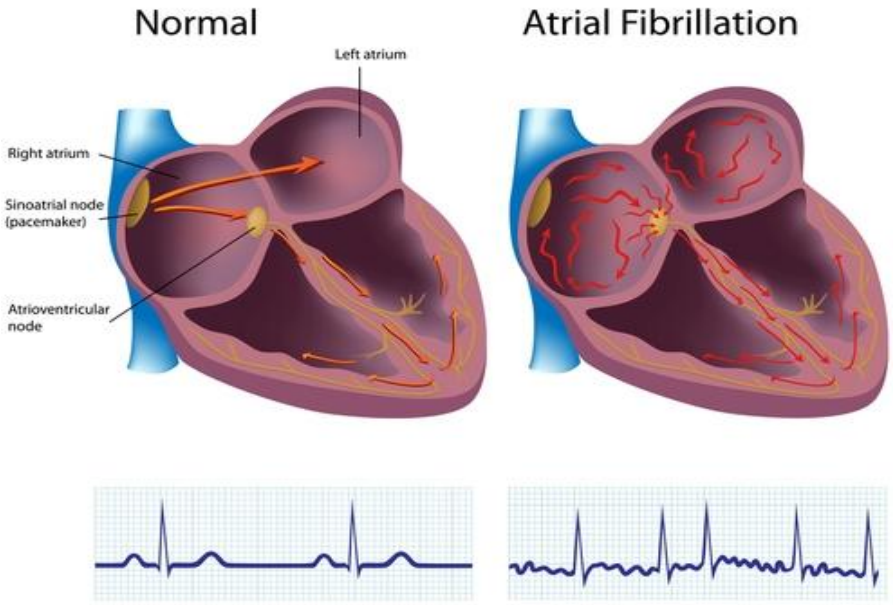
Dry mouth symptoms can be alleviated by encouraging the patient to sip water (if safe swallow) or dentists can prescribe artificial saliva substitutes. Dentists may also prescribe high fluoride toothpastes or fluoride varnishes for people at increased risk of dental decay.

The NHS Fife Public Dental service welcomes self referrals from patients and healthcare professionals across the region. We have fully accessible clinics throughout Fife, several with hoisting facilities. We can also provide domiciliary care in patients' own homes, care homes and wards where appropriate. Our team of Special Care Dentists, Dental Therapists, Hygienists and Dental Nurses are experienced in caring for patients following a stroke.

For further information contact: Katrina McCormack on katrinamccormack@nhs.net

Atrial Fibrillation- How can we do better?

The SSNF is supporting the campaign to improve the treatment of AF across Scotland. At the committee meeting in May 2016, Angela MacLeod from the Stroke Association provided us with an update on the campaign and its progress to date.



AF, paroxysmal AF and atrial flutter puts you at increased risk of stroke and it is essential that everyone with it is risk assessed using the CHA2D2-VASc and HAS-BLED tools. Aspirin alone is ineffective in stroke prevention in this group and it is essential that their treatment is optimised.

CHA_2DS_2-VASc score

Risk Factor	Score
C - Congestive heart failure	1
H - Hypertension	1
A - Age ≥ 75 yrs	2
D - Diabetes mellitus	1
S_2 - Prior stroke or TIA	2
V - Vascular disease	1
A - Age 65-74 years old	1
Sc - Sex category (female)	1

Lip GYH, Halperin JL. Am J Med 2010;123(6):484-488.

The CHAD2D2-VASc will identify those most at risk of stroke and HAS-BLED will calculate their bleeding risk on these drugs. It is important to note that falls alone does not justify the with-holding of anticoagulation and for most people the benefits will outweigh the risk.

As I am sure you are aware the Scottish Stroke Care Audit collects data on the incidence of AF in all patients with a stroke/ TIA diagnosis. It also monitors the appropriate use of anticoagulants in this group. This data is published in the SSCA Annual Report available on www.

As a stroke nurse you need to raise the awareness of appropriate treatment for your group of patients and ensure that timely and appropriate treatment is being delivered. The SSNF would recommend that you update your knowledge by completing the HeartE module available on www.heartelearning.org

Update from the Scottish Stroke Care Audit 2016

Moranne MacGillivray, Clinical Coordinator

Scottish Stroke Care Audit (SSCA)

SSCA Annual National Report – the SSCA annual national report was published on 12th July 2016 – this was different from previous reports because we did not print hard copies but aimed to disseminate it widely in electronic format. We also produced hospital level data which were directed at the public available via Tableau on the website. The report was also broadened to include a description of progress against the Scottish Governments Stroke Improvement Plan.

The 2016 report is currently available at
http://www.strokeaudit.scot.nhs.uk/Publications/Main.html

SSCA National Meeting - our annual meeting took place on 23rd August and following the success of last year's meeting aimed to not only update delegates on the audit results, but also on quality improvement projects and the cutting edge of stroke practice. Feedback from the event has been very positive.

Rehabilitation Sprint Audit - the Rehabilitation Audit has been completed - analysis of the data was presented at the SSCA National Meeting – the SSCA Rehab subgroup will meet soon to discuss the next steps.

Annual Stroke MCN Health Board Review - visits for 2016-17 are being planned. The reviews now incorporate an escalation process involving the Scottish Government to ensure that Health Boards are using the SSCA data to continue to drive improvement in patient care. As part of the agreed Scottish Stroke Improvement Plan review process, the data for each Board are also reviewed six months following each Board review meeting to ensure that actions have been taken and improvements made as agreed.

Scottish Stroke Care Standards - in 2016 we revised the Scottish Stroke Standards to ensure that they remain challenging, to continue to drive the process of service

improvement. These standards came into effect as of 1st April 2016 – further information can be found on the website.

http://www.strokeaudit.scot.nhs.uk/Quality/Scottish_Stroke_Care_Standards.html

See table below for a summary the 2016 Scottish Stroke Care Standards:

Topic	Scottish Stroke Care Standards, April 2016
Stroke Care Bundle	**80%** of all patients admitted to hospital with a diagnosis of stroke should receive the appropriate elements of the stroke care bundle.
Access to Stroke Unit	90% within 1 day of admission (Day 0 and 1).
Brain imaging	**95%** within 24 hours of admission.
Swallow screen	**100% within 4 hours of admission.**
Aspirin administration	95% of ischaemic strokes within 1 day of admission (Days 0 and 1).
Delay from receipt of referral to specialist stroke/TIA clinic	80% are assessed within 4 days of receipt of referral (Day 0 being day of receipt of referral).
Thrombolysis	80% receive the bolus within one hour of arrival at hospital. **50% receive the bolus within 30 minutes** of arrival at hospital.
Carotid Intervention	80% undergoing carotid endarterectomy for symptomatic carotid stenosis have the operation within 14 days of the event that first led them to seek medical assistance.

If you would like more information please contact: moranne.macgillivray@nhs.net or Tel Moranne MacGillivray on 0131 275 7615 or contact your local Stroke Managed Clinical Network Lead

Goodbye, Farewell, Auf Wiedersehen, Adieu Campbell Chalmers

As I am sure many of you are already aware, Campbell Chalmers the Chairperson of the SSNF will leave us at the end of the 2016 SSNF Conference in Perth. Campbell has moved to a whole new set of challenges taking up the Directors post in the Royal National Institute for the Blind Scotland.

Campbell started his nurse training in 1983 in Learning Disabilities and completed his RGN training in the late 80's. He has worked in various posts in Glasgow and Edinburgh and in 2000 became the Director of Advice and Support for CHSS. In 2001 he was one of the founding members of the SSNF and has during that time served as Secretary and in 2012 stepped into the Chairperson's role.

He was appointed as Scotland's first Stroke Nurse Consultant in 2007 for NHS Lanarkshire. He has been involved in many developments within stroke nursing including the SCoT competency toolkit, The Stroke Game, STARs and many SIGN Guidelines and Best Practice Statements to name but a few. Campbell has been the voice for the SSNF on Scottish Government and NHS Scotland committees and has been instrumental in making sure that the role of the stroke nurse has been heard, recognised and has been a wonderful representative for the SSNF for more than 15 years.

We will miss him and hope that you will join us in wishing him good luck in his new post. If he fulfils that with as much enthusiasm as he has for stroke then he will do an excellent job and our loss is the RNIB's gain.

Thanks to everyone who has contributed to this newsletter. If you would like any further information on any of the articles please contact: Linda Campbell on linda.campbell8@nhs.net