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DECLARATION

I hereby declare that the work presented in this study for the degree of Bachelor of Science in Nursing has not been presented either in part or wholly for any other degree and is not currently submitted for any other degree.

Signed: _____

Candidate

Approved: _____

Supervising Lecturer

STATEMENT

I hereby certify that this study is entirely the result of my own independent work. The various sources I am indebted to are fully acknowledged in the paper and references.

Signed: _____

Candidate

DEDICATION

To Jane and Adolph, ...

My dear parents and friends.

ABSTRACT

This study was a descriptive survey aimed at finding out the problems stroke patients had after discharge from hospital. The research setting was Lusaka Urban and the sample was drawn from stroke patients who had been admitted into the University Teaching Hospital (U.T.H) in the year 1989.

The Literature reviewed was centred on the care of longterm patients and their preparation for homecare.

The purpose of the study was achieved by interviewing ten stroke patients and their carers. Data were collected, processed and analysed manually.

The results of the study revealed that patients and carers were inadequately prepared for discharge from hospital. It also revealed that Doctors and Nurses do not consistantly communicate with the patients and their relatives about the diagnoses they come up with.

Most patients expressed that they desired to have had more information about the course of their condition.

It is hoped that health personnel will recognise the need to use the Holistic approach in patient care.

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CHAPTER 1

INTRODUCTION

'Stroke is defined as rapidly developed clinical signs of focal (or global) disturbance of cerebral function, lasting more than twenty four hours or leading to death, with no apparent cause other than of vascular origin'

World Health organisation

Despite lack of data on stroke in Zambia there seems to be a lot of stroke patients either in hospitals or communities. Once discharged from hospital these patients are cared for by relatives at home and since their condition is long term this poses rehabilitation problems.

British Statistics show that western countries all have incidence rates of about 150 - 250 per 100 000 population per year. Wade (1985).

Wade goes on to say there are three types of risk factors for hypertension. These are :-

- Relative risk - this defines increase in risk associated with the possession of some characteristic (eg hypertension) compared with a similar person lacking that characteristic.
- Attributable risk - indication of the proportion of strokes accounted for by a particular factor.
- Absolute risk - the rate which possessors of an attribute (eg hypertension) will actually have strokes.

In Zambia strokes seem to be predominantly a sequelae of hypertension. Most of the stroke patients come into hospital with undiagnosed hypertension which is only discovered on admission.

Carr and Shephered (1986) state that stroke is a medical emergence which requires accurate diagnosis, and optimum care which can be best given in hospital. They advocate for rehabilitation after stroke. Management of stroke patients in Zambia involves admission of the patient into hospital lowering the blood pressure and referral to the physiotherapists for rehabilitation.

This study aims at discovering what happens to the stroke patients at home sinc most of these patients never come back to the hospital after discharge.

IDENTIFICATION OF THE PROBLEM

From experience with stroke patients in four Zambian hospitals, the investigator has found that most of them are admitted into hospital, have their blood pressure controlled, some physiotherapy treatment and get discharged. No follow up care of any kind is given.

Throughout the patients hospitalisation relatives are not involved in activities like bed baths or in the rehabilitation programme. However after the patient gets home the relatives are expected to assist the patient with activities of daily living.

With this in mind one wonders how the patient and the family cope and adjust at home and if there are any support systems for them.

The investigator has seen a patient being brought back to the hospital all because the family expected him to recover quickly while another family felt that their relative (patient) should be taken to his village to die there. This gives the impression that there could be some misinformation or non - information between hospital staff and relatives of the stroke patients.

Among the twenty nine stroke patients that were admitted in 1989 only four came back to the hospital for their physiotherapy treatment. It is not known as to what is happening to the twenty five who have never returned to the hospital.

This has led to this investigative study to find out the problems that stroke patients have after discharge from hospital.

STATEMENT OF THE PROBLEM

Stroke is a disabling condition which calls for longterm rehabilitation if the patient is to regain some degree of independence.

Rehabilitation for stroke patients discharged from the University Teaching Hospital (U.T.H) is undertaken by the physiotherapy department which is based within the hospital. The patients who benefit from this programme are those patients who keep their appointments and keep returning for treatment until they are discharged from the physiotherapy list. Some patients never return once discharged

For instance, twenty-nine stroke patients were admitted into the U.T.H in 1989 and only four have been recorded to have come back for physiotherapy treatment. The question then that arises is why have the other twenty five patients not come back and what is happening to them in the community?

Since there is no established follow-up system for these patients what happens to them in their homes is not known. A discharge from hospital for a stroke patient does not imply recovery but a delayed 'cure'. Field, (1958). This means that the patient may only be having the support of his family.

Family support would only be advantageous if the family members know what to do for the patient. As Travis (1961) states, the knowledge and attitudes of the major caretaker vitally affect physical restoration. This then calls for family involvement and not exclusion during the patients stay in hospital. This would give the family members some knowledge about the care of a stroke patient. The family has to live through every day of the patients life assisting him in activities of daily living, ambulation, feeding and speech problems. Carr and Shepherd (1982). For those who regain some degree of independence these could be job placement problems.

This study therefore seeks to find answers to the question , What happens to stroke patients in the community?

HYPOTHESIS

Stroke patients have rehabilitation problems after discharge from hospital.

OPERATIONAL DEFINITIONS

For the purpose of this study the following definition of terms will be used:-

1. Primary Care Giver :- the person identified by the patient as the one most responsible for meeting the patients' daily physical needs in the home.
2. Community Help :- agencies or health personnel with skills to enable them to be involved in the rehabilitation programme of stroke patients.

OBJECTIVES OF THE STUDY

General Objective

To establish problems that stroke patients have after discharge from hospital.

Specific Objectives

1. To identify preparations made by the ward for patients follow-up on discharge.
2. To identify the knowledge the patients relatives have about the care that should be given to the patient.
3. To identify the help the community offers to the patient.
4. To establish which problems the patient views as being the major ones.
5. To make suggestions to the health department of the Lusaka city council for action.

RATIONALE OF THE STUDY

Since stroke patients have varied problems like aphasia, feeding, ambulation and in general the carrying out of activities of daily living, the study will try to find out how these patients cope and adjust in the community.

The Primary Care Giver also have problems peculiar to themselves. The study will also bring out these problems and how the carers cope and solve them.

For the patients who have never returned to the hospital for physiotherapy

treatment the study will seek to reveal the constraints involved and whether patients are getting any kind of community help.

The information to be obtained by this study can be used to try and resolve the problems of stroke patients and it can also be used as baseline data for the initiation of community support systems for both the patients and relatives.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

Literature review focused on stroke patients and their long term care. Since stroke is a long term condition, literature on care of longterm patients generally, was reviewed.

In this study literature was reviewed and discussed under the following headings:-

- Preparation of the patient for discharge
- Inclusion of the family in the care of the patient
- Follow-up care
- Rehabilitation activities
- Studies on long term illness

PREPARATION OF THE PATIENT FOR DISCHARGE

Field (1958) observed that for most patients, discharge from hospital poses problems for the patient, as well as for those closely associated with him. His adjustment in society will depend on his physical condition, what awaits him in the world outside, and in part by his emotional make-up and his usual way of meeting life experiences in general.

It goes on to say the patient should be helped to give up the protection provided by the hospital experience without overwhelming fear but with some hope for the future. The patient needs to be provided with some means of achieving a sense of security and of finding satisfactions in the world outside. It is difficult to give answers to questions like. 'Where do I go from here?' and 'Where do I get the care I still need?'

Field (1958) concludes by saying:-

> 'Not only does the patient have the normal need to be wanted, to be loved and to be useful, regardless of his limitations, but this can be accentuated by his very helplessness.'

He needs his family to support him.

Worstall (1987) also reiterates the need for family involvement in the care of the patient before discharge. This is so because once discharged the

whole family has to adjust to having someone who is ill in the home.

In the ccnclusion of her article 'Caring for Kathleen' Worstall states that the carers of chronically ill patients need a short course on what to do and to expect. This would ease their fears about doing the wrong thing sometimes.

In the Zambian setting it appears that patients, generally, are on the receiving end. They are told their diagnoses, given treatment and discharged. If they do not ask, the patient will- in this case - know he has stroke and should come back.for review as advised by the Doctor. The causes of this may be varied but from observation nurses and doctors in the major hospitals are overworked and and nurse-patient ratios are unbalanced. As a result nurses concentrate on tasks to be done than stopping and discussing patients' conditions with the patients and their relatives.

In such a situation a patient may become dependant on hospital care or may decid to spend a lot of money seeking different kinds of treatment through ignorance.

INCLUSION OF THE FAMILY IN THE CARE OF THE PATIENT

Field (1958) states that it is important to recognise that the attitude of the family members is an important factor, facilitating or retarding the patients progres it devolves upon those concerned with the patients' care to help them handle some of these problems so that they may find release and not be forced to rent their feelings upon the patient.

A good example of this is given by Dobson (1984). She cites an incident where discharge of a stroke patient from hospital was delayed not because of the nature of the illness but because his family refused to take care of him. The reason the family gave was there was no room for him in his own home anymore.

The researcher thought this would be highly unlikely in the Zambian situation where there are strong extended family ties. What would happen would be to accept the patient back home but because of lack of knowledge and fear of the unknown, the patient may be neglected.

Worstall (1987) states that it should be realised that carers are always on duty - no eight hour shifts - and are continually worried about whether they are

doing the right things?

Brunner and Surddath (1975) state that the patients' family plays an important role in his recovery and they should be included in the care of the patient.

FOLLOW-UP CARE

Consistent follow up of the stroke patient is necessary if the patient has to recover fully. Luckman (1974) says that successful rehabilitation is not achieved without detailed planning. Among some of its objectives are retraining of the patient to achieve maximum independence and to help the patient adjust successfully psychologically and socially.

Rehabilitation of the stroke patient is on-going even after discharge from hospital. As Felton (1965) puts it, a stroke patient who recovers presents an enormous community problem in rehabilitation. Seeing that the majority of stroke patients live in the community, the community health nurse may be well placed to act as the key worker. HUdson and Hawthorn (1989).

In Zambia this seems to be a problem area. Most stroke patients come back to the hospital whenever they have problems. They seem to have no-one in the community to assist them. The hospital and the community services seem to function independent of each other. James (1962) sums up all this by giving five criteria of good medical care. These are:

'1. Comprehensiveness - a programme is comprehensive when it makes available to each patient all the techniques and services he requires for adequate medical care.

2. Continuity of care - each patient should be cared for by a single physician. If this is impossible, to send to his new physician an up to date, complete and accurate medical and social record showing exactly what has already been done for him.

3. Medicine should be family centred: Disease is a family phenomenon and its effective treatment and rehabilitation should make us of and community strength which may exist and in that the family is number one.

4. Preventive services

5. Highest quality - Professionals should be professional people. High quality care must be extended to out patients departments, home care programmes, home visiting, nursing homes and homes for the aged.'

From observation our health care system greatly falls short of these criteria. These criteria call for the use of all techniques and services, proper referral of patients, family involvement and activities like home visiting. It appears that this does not happen in Zambia and if ever it happens then it must be on a small scale.

REHABILITATION ACTIVITIES

Luckman (1974) states that rehabilitation for a stroke patient starts with admission. Early in his illness the patient is made to realise that he is expected to do certain things for himself.

Katz and Felton (1965) add that the stroke patient who recovers presents an enormous community problem in rehabilitation. This, they say, is so because the length of time taken to rehabilitate the patient is not known before hand. For example, speech therapy may take many months and sometimes years of kindly effort, because relearning takes place by repetition in an emotionally advantageous climate.

Brunner and Suddarth (1975) state that the patient needs to be retrained. He should maintain the correct posture all the time. The affected extremities have to be put through a full range of motion four or five times a day. Generally as the condition permits the patient should be taught self care activities.

In conclusion they say any member of the health team coming into contact with the patient should encourage him to keep active, faithfully adhere to his exercise programme, accept his limitations and confidently remain as self sufficient as possible.

In Zambia rehabilitation of stroke patients starts as soon as the patients condition allows. The patient is usually told the importance of adhering to the rehabilitation regime. The major drawback here is that supervised rehabilitation programmes are hospital based and there appears to be no centres to cater for stroke patients in the community. It then becomes a problem to maintain a continuous retaining programme.

STUDIES ON LONG-TERM ILLNESS

Muditt (1987) cites that home may be the most appropriate place for many of the dying to be nursed, but it may also be a place of much suffering and distress where unmanageable burdens are borne by informal carers. She goes on to say carers should be prepared by the ward nurses to take on their caring roles.

This is very important since these carers are all alone at home with the patient. If this is done then there is a possibility of a continuous retraining programme should the patient fail to keep his review appointments with the physiotherapists or occuptaional therapists.

Muditt, in her exploratory study 'providing full-time care for the terminally ill at home' under the title 'Home Truths' found the following:

- Primary carers felt they would bear most of the responsibility for meeting patients' physical needs after discharge.
- The prospect of caring for an advanced cancer patient at home caused great anxiety.
- Hospital staff were perceived as not providing satisfactory information to relatives
- Respondents were able to list common causes of concern and factors which caused great anxiety.

Mudditt goes on to say that relatives commonly need to learn skills related to ambulation, comfort, skin care and bowel management. She also says virtue of their close contact with patients and relatives, nurses are ideally placed to prepare relatives for their teasks ahead. Evidence in Mudditts study shows that there are clear benefits to be derived from information - giving and teaching, which can help reduce stress and prepare informal carers for their task.

Lack of explanation of the patients' condition to the patient himself and his family will lead to insecurity and lack of confidence in carers. They will fear doing the wrong thing when they actually want to help the patient.

CONCLUSION

The literature reviewed shows that there is need forpreparation of the patient and family for discharge from hospital if there has to be continuous retraining

of the patient. Follow-up will help re-inforce the care given by informal carers and help instill confidence as they give care. This will also motivate the patient to work toward optimum independence.

The literature has also revealed that carers and patients have problems peculiar to themselves and these are what should either be prevented or solved.

CHAPTER 3

METHODOLOGY

RESEARCH DESIGN

A descriptive survey design was used. This design was chosen because the study was non experimental. It aimed at discovering the status quo in respect of stroke patients in the community. The design helped gain insight into problems the stroke patients are currently facing.

The patients and their relatives were interviewed in their homes. Due to non - availability of funds this design was thought to be the best because it does not require a lot of funds.

This was a prospective study.

RESEARCH SETTING

The study population was selected from Lusaka Urban which covers Chilanga in the south, Zani Muone motel in the north, Garden Motel in the West and the international airport in the East.

It is made up of low, medium and high density residential areas. It has a population of approximately 1.2 million and this population is served by twenty two health centres. There are no rehabilitation centres that can cater for stroke patients. In the whole of Lusaka Urban, excluding U.T.H, there are six doctors attached to the Health Centres and three administrators based at the Civic Centre. There are ten Public Health Nurses and four of these are in the community.

SAMPLE: SELECTION AND APPROACH

A sample of fourteen subjects was drawn from the target population using purposive sampling since it was not known whether these patients would be found in their homes.

The sample for this tudy was selected from the 1989 records in the medical wards. The patients whose addresses were incomplete were not included in the study. Altogether there were twenty nine stroke patients recorded in the hospital medical wards admission books. Out of these only fourteen had complete addresses recorded.

THE INSTRUMENT

Data was collected using a structured interview schedule. This helped obtain primary data furthermore the investigator was able to get information from both literate and illiterate people. This kind of instrument was chosen also because it has a high response rate.

To check the instrument for clarity the questionnaire was pre-tested on dependant patients and their relatives in medical wards.

DATA COLLECTION

Data were collected during the month of July, 1990. Interviews were conducted on both patients and their carers. The data was analysed manually with the aid of pocket calculator.

CHAPTER 4

DATA ANALYSIS AND PRESENTATION OF FINDINGS

PRESENTATION OF FINDINGS FROM PATIENTS

The results of the study have been presented in tabular form and some of the variables have been cross-tabulated to show relationships between them. Four respondents were not found at the addresses given.

TABLE 1: SEX DISTRIBUTION OF RESPONDENTS

SEX	NO. OF RESPONDENTS	PERCENTAGE
Female	2	20
Male	8	80
Total	10	100

TABLE 2: AGE DISTRIBUTION OF RESPONDENTS

AGE IN YEARS	NO. OF RESPONDENTS	PERCENTAGE
25 - 34	1	10
35 - 44	1	10
45 - 54	3	30
55 and above	5	50
TOTAL	10	100

Most of the respondents were aged 45 years and above.

TABLE 3: COMPARISON BETWEEN LENGTH OF TIME WITH STROKE AND EXPLANATION OF CONDITION TO PATIENT

LENGTH OF STAY IN YEARS	EXPLANATION		TOTAL NO OF RESPONDENTS	PERCENTAGE
	YES	NO		
0 - 6/12	-	-	-	-
7/12 - 1	5	1	6	60
11/12 - 16/12	2	3	3	30
17/12 - 2	1		1	10
TOTAL	8	2	10	100

Most of the respondents had their condition explained to them.

TABLE 4: COMPARISON BETWEEN EDUCATIONAL STATUS AND SATISFACTION WITH INFORMATION GIVEN

EDUCATIONAL STATUS	SATISFACTION		TOTAL NO OF RESPONDENTS	PERCENTAGE	NO INFORMATION GIVEN
	YES	NO			
Primary	+	1	2	20	-
Secondary	4	1	6	60	2
College	-	-	-	-	-
University	-	-	-	-	-
None	1	1	2	20	-
TOTAL	60	20	10	100	20

All respondents with secondary education who were given information about their condition were satisfied with it and 50% of those with primary and no education were not satisfied with the information they received.

TABLE 5: COMPARISON BETWEEN SATISFACTION WITH EXPLANATION OF CONDITION AND THE INFORMER

INFORMER	SATISFACTION		NO OF RESPONDENTS	PERCENTAGE
	YES	NO		
Doctor	3	2	5	50
Nurse	1		1	10
Med. Student	1		1	10
Physio therapist	1		1	10
None	-	-	2	20
TOTAL	6	2	10	100

Half of the respondents had their condition explained by a Doctor and two of them were not satisfied with the information received. Three of the respondents had their condition explained by a nurse, a medical student and physiotherapist and they were satisfied with the information. Two respondents were given no explanation whatsoever.

TABLE 6: COMPARISON BETWEEN MARITAL STATUS AND RELATIONSHIP WITH CARE GIVER

MARITAL STATUS	RELATIONSHIP WITH CARE GIVER				NO OF RESPONDENTS	PERCENTAGE
	HUSBAND	WIFE	SISTER	MOTHER		
Married	8	-	-	1	9	90
Single	-	-	1	-	1	10
TOTAL	8	-	1	1	10	100

All married males are cared for by their wives and the female is cared for by her daughter. The single respondent is cared for by the sister.

TABLE 7: COMPARISON BETWEEN INSTRUCTIONS GIVEN TO RESPONDENTS TO FOLLOW AT HOME AND THEIR LEVEL OF DIFFICULTY

INSTRUCTION GIVEN	LEVEL OF DIFFICULTY				NO. OF RESPONDENTS	%
	EASY	VERY EASY	DIFFICULT	VERY DIFFI.		
Keep review dates			1		1	10
Keep review dates and attend physio dept			1		1	10
Continue exercise at home		1	1	1	3	30
Continue exercise at home and take medication and keep review dates	1			1	2	20
Continue exercise and have correct diet	1				1	10
Continue exercise and not to take medicines without advice		1			1	10
Eat a lot, continue medication and rest	1				1	10
	3	2	3	2	10	100

One of the respondents who found it very difficult to keep review dates and attend physiotherapy department was actually found very drunk. Most of those who had this problem lacked finances for transport to keep coming to the hospital since they had stopped working.

TABLE 8: WHAT RESPONDENTS THOUGHT HEALTH PERSONNEL SHOULD DO TO HELP WITH THEIR HOME CARE

	NO OF RESPONDENTS	%
1. Follow up of patients	2	20
2. Give more information about course of illness	2	20
3. Involve family and employers in the care of the patient and educate clerks in hypertension clinic on how to deal with people well	1	10
4. Give enough medication to cover the period before review date	1	10
5. Educate patients and carers on the condition	1	10
6. Nothing	2	20
7. I don't know	1	10
TOTAL	10	100

PRESENTATION OF FINDINGS OBATINED FROM CARERS

TABLE 1: SEX DISTRIBUTION AMONG RESPONDENTS

SEX	NO OF RESPONDENTS	PERCENTAGE
Female	10	100%
Male	-	-
TOTAL	10	100%

TABLE 2: AGE DISTRIBUTION OF RESPONDENTS

AGE IN YEAKS	NO OF RESPONDENTS	%
25 - 34	1	10
35 - 44	5	50
45 - 54	3	30
55 & above	1	10
TOTAL	10	100

Most of the respondents were aged between 35 and 44 years.

TABLE 3: COMPARISON BETWEEN LENGTH OF TIME CARING FOR THE PATIENT, WHETHER OR NOT INFORMATION ABOUT CARE WAS GIVEN AND LEVEL OF SATISFACTION WITH INFORMATION

LENGTH OF TIME CARING FOR PATIENT	INFORMATION GIVEN		LEVEL OF SATISFACTION WITH INFORMATION				NO OF RESP.	PERCENTAGE
	YES	NO	SATIS	VERY SATIS.	DISSAST.	VERY DIS.		
9/12	1	1		1			2	20
10/12	1	1	1				2	20
1 year		1					1	10
1 3/12	1	1			1		2	20
1 4/12	1		1				1	10
1 6/12		1					1	10
1 7/12		1					1	10
TOTAL	4	6	2	1	1		10	100

60% of the carers got no information at all about how to care for the patients. 40% were given some information and 20% were satisfied with the information given.

TABLE 4: INFORMATION THE CARERS WOULD HAVE LIKED TO RECEIVE

INFORMATION	NO OF RESPONDENTS	PERCENTAGES
1. Diet of the patient	1	10
2. Where to get further help and how to care for the patient at home	1	10
3. Diet and treatment at home and method of feeding	1	10
4. Care at home and course of illness	3	30
5. Nothing	1	10
TOTAL	7	70

This information was from the respondents who did not get any information and the one who got information but was not satisfied by it. Those who got information and were satisfied were 30%.

COOMUNITY RESOURCES ASSISTING IN CARE OF PATIENT

All respondents stated that there were no other agencies helping in the care of the patient. They were not referred anywhere when they left the hospital. When t they need help they get it from the following:-

Hospital and traditional healers	-	10%
Traditional Healers	-	10%
Private Doctors	-	10%
Clinic (Health Centre)	-	10%
Hospital	-	60%
Total	-	100%

TABLE 5: WHAT HEALTH PERSONNEL SHOULD DO TO HELP CARERS

WHAT SHOULD BE DONE	NO OF RESPONDENTS	PERCENTAGE
1. Teach carers exercises to be done at home	2	20
2. Explain course of illness	3	30
3. Discuss effects of illness on patient and where to get help within the community	4	40
4. Nothing	1	10
TOTAL	10	100

The respondent who said there was nothing that could be done was found drunk so the response is not very reliable.

CHAPTER 5

DISCUSSION OF FINDINGS, NURSING IMPLICATIONS, CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

DISCUSSION OF FINDINGS

The study sought to find out the problems storke patients have after discharge from hospital. The sample was drawn from Lusaka Urban District. The sample constituted of ten stroke patients and their carers.

Findings of the study revealed that two (20%) of the patients were females and eight (80%) were males. The age distribution as shown in Table 2 revealed that 80% of the patients were aged forty five years and above. This can be explained by the fact that most chronic conditions of which hypertension is one are more prevalent in the elderly. For the patient who was aged between twenty five and thirty four years a tentative explanation could be that there could at the time of the stroke, have been an underlying health factor which caused her to have a raised blood pressure leading to a stroke. Her blood pressure has since been controlled and she is not on any medication.

For Carers the sex distribution is 100% females. History shows that females have always been the care-givers to the sick in any community. This could be attributed to their maternal instincts. Findings on the relationship between patient and carer seems to prove this. Table 6 in the patients findings shows that all the married men were cared for by their wives and the female patient instead of being cared for by the husband, she was cared for by the daughter. The single patient was under the care of her sister.

The age distribution of carers to a larger extent matches that of the patients because most of the patients were cared for by their spouses.

Table 3 shows that 80% of the patients had their condition explained to them though some say they were told they were paralysed because they had a stroke due to a raised blood pressure. This they said that did not satisfy them since they 'had not been hypertensive before.' Nobody seemed willing to explain this to them. 20% never had their condition explained to them. This is

very unfortunate because the patient has a right to have his condition explained to him. His right, therefore in this case was violated.

Hood and Dincher (1984) state that "Although the patients' rights have not been universally adopted by health care agencies, pressures in the United States of America are rising requesting health agencies to adopt standards and respect patients rights". One of these rights is the patients' right to obtain information from his physician which should be current and complete on issues such as diagnosis, treatment and prognosis in terms the patient can reasonably understand.

Very few individuals in Zambia can understand their condition if they have had a very low education. Table 4 shows that patients with secondary education given to them. Those with primary education and those with no education at all were not satisfied with the information they received.

Table 3 for the carers shows that 60% never had any information given to them about how they should care for the patients. This finding is unfortunate in view of what Worstall (1987) stated about carers being on duty always. The work they have to do will seem formidable without a knowledge base. As Mudditt (198 found out therefore, primary carers bore most of the responsibility for caring for the patient; hospital staff were not providing satisfactory information to relatives. This study's findings seem to confirm her findings of the 40% that received information. 20% were not satisfied.

Table 5 (patients) shows that the Doctor explained to five of the patients and the nurse explained to one. Two patients as earlier mentioned did not get any information and the physiotherapist and medical student each explained to one patient. This though is not very good. It shows that the Doctor made a diagnosis and did not communicate to the patient and the nurse, despite being with the patient twenty four hours of the day she never communicated the diganosis to the patient. This may be explained by the fact that there are too many patients under the care of one nurse. This makes the nurse fail to

to give the time she should to each of her patients. Chilufya (1990)

Most of the carers who did not get any information or were not satisfied with the information given felt they would have liked to be told how to care for the patient at home. They also said they wanted to know more about the course of the illness. Others would have appreciated knowing the diet of the patient and where they could get further help if the need arose. (Table This all comes back to inclusion of the family in patient care so as to prepare them adequately to care for the patient at home. It also raises the isuue of referral of a aptient to readily available assistance within the community. All this si stated in James' (1962) five criteria of good medical care.

Table 7 (patients) shows that 50% of the respondents found it easy to keep the instructions given and 50% found it difficult. Most of those who found it difficult had financial problems that prevented them from coming for review. This may be explained by the long time needed to rehabilitate stroke patients. The one who was found drunk actually holds a 'shebeen' for illicit beer drinkers. Beer itself is a stressor on health hence it does not help the patient. Such problems cannot be known without proper follow up of these patients.

All respondents among the carers stated that they were not referred to any other agency and most said apart from the hospital they did not know of any other place they could get help from. Wherever they went for help it was just to try 'their luck'. 10% of the carers said they solicited for help from the hospital and traditional healers and the other 10% went exclusively to traditional healers. Anothe 10% went to private Doctors. Lack of information about the proper agencies to go to strains the patients finances. As in this case the patients were paying for services that did not relieve the paralysis they wanted treated. 70% of the patients attend the Government health institutions.

Table 8 for patients and Table 5 for carers state what health personnel should do to help in the home care of the stroke patient. What emerged most from both tables was the need to know more about the condition, its course and its effects. Others also thought health personnel should follow-up thet patients at home and involve the family in the care.

One patient stated that receptionists in the hypertension clinic were very rude. This angered him and other patients each time they went to the clinic for review. This in itself is sad because anger raises blood pressure therefore these patients are seen by the Doctor with a raised blood pressure due to anger and not the 'normal' high blood pressure they normally have. This in turn affects the treatment they get. The patients suggestion therefore is justif

SUMMARY

The findings of this study give evidence that stroke patients have problems. Not only do they have problems peculiar only to themselves but also those that care for them are affected. The patients are not well prepared for discharge. They and their relatives go home not knowing how they will cope. Patients are not followed up at home to at least assess the conditions they will live under.

Both patients and carers still have questions that remain unanswered as they try to cope at home.

NURSING IMPLICATIONS

The findings of the study are very dissappointing and raise a lot of questions for the health personnel in general and the nurse and doctor in particular.

There is need therefore to give a little more time to a patient. At least to explain his condition to him. Failure to do this is failure to do one's duty towards the patient. Nurses and Doctors should be open to the patients and their relatives so that they can be asked for clarifications in diagnosis, instructiows or whatever else the patient may not understand.

Health personnel should be able to communicate accurately and effectively. Clemen et al (1981). They should care for the patient as a whole together with the family he comes from since disease is a family phenomenon.

The suggestions the patients and carers have made/given an idea of which areas in the care of stroke patients are not given the attention they should.

CONCLUSION

The study brought into focus the problems faced by stroke patients in their homes. It was proved that they are problems that, with just a little more time, health personnel can solve.

From the findings of the study it is evident that an effective discharge plan is one that will encompass short term as well as long term goals such as:-

1. Information about patients' condition
2. Diet and medications
3. Resources for additional help
4. Implications for the family and carers.

The hospital health personnel should therefore realise that they are accountabl for the patients' well being even after discharge from hospital.

RECOMMENDATIONS

1. A similar study should be conducted using the case study and on a larger scale to confirm findings of this present study.
2. A policy of referring stroke patients to specific communities should be forwarded by hospital authorities.
3. All medical units should design a form that can be used to audit the discharge plan that has been implemented for patients.
4. Formation of support group among stroke patients

LIMITATIONS OF THE STUDY

1. Time in which the study had to be done was too short and the funding was inadequate.
2. The sample size was too small to generalise the findings to the 1989 population of stroke patients.

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22nd May, 1990

The Executive Director
University Teaching Hospital
P.O. Box 50001
LUSAKA

u.f.s. The Head
Department of Post Basic Nursing
University of Zambia
P.O. Box 50110
Lusaka

Dear Sir,

Re: RESEARCH PROJECT

I am a 4th year student studying for a Bachelor of Science Degree in Nursing. In partial fulfilment of the requirements for my study, I am required to conduct a research study in the course NR 420 (Nursing Research). My topic of study is: Stroke: an investigative study into the problems stroke patients have after discharge from hospital.

I would be most grateful if you could allow me to get figures of the stroke patients who were admitted in the years 1987 and 1988.

Yours sincerely,

Ms. Catherine Chilufya

STRUCTURED INTERVIEW SCHEDULE FOR CARERS

		for official use only
1	Sex a) Male .... b) Female	☐
2	How old are you? a) 24 years and below .... b) 25 - 34 .... c) 35 - 44 .... d) 45 - 54 .... e) 55 and above	☐
3	What is your relationship with the patient?	
4	For how long have you been caring for the patient?	
5	Were you given any information about caring for the patient during his/her hospitalisation? a) Yes .... b) No	☐
6	If 'Yes' to number 5, were you satisfied with the information given to you? a) Satisfied .... b) Very satisfied .... c) Dissatisfied .... d) Very dissatisfied	☐
7	If 'No' to number 5, what information would you have liked to receive? a) ..... b) ..... c) ..... d) ..... e)	

8	Are there any community resources assisting you with the care of the patient?	for official use only
	a) Yes	☐
	b) No	
9a	If 'Yes' to number 8, name the agency	
	.....	
9b	How did you know about the agency?	
	a) Through referral fom Hospital	☐
	b) Through friends	
	c) Through the Community health Centre	
	d) Others - Specify	
10	If 'No' to number 8 where do you get help when in need of professional help on the care of the patient?	
	a) Clinic	☐
	b) Hospital	
	c) Others - specify	
11	What do you think health personnel (Doctors and Nurses) should do to help you more?	
	.....	

Thank you

STRUCTURED INTERVIEW SCHEDULE FOR THE PATIENT

		for official use only
1	Sex	
	a) Male	☐
	b) Female	
2	How old are you?	
	a) Below 24	
	b) 25 - 34	☐
	c) 35 - 44	
	d) 45 - 54	
	e) 55 and above	
3	What is your marital status?	
	a) Single	
	b) Married	☐
	c) Divorced	
	d) Widowed	
4	What is your educational attainment?	
	a) Primary School Level	
	b) Secondary School Level	☐
	c) College Level	
	d) University Level	
5	For how long have you been out of hospital?	
	.....	
6	What is your relationship with your primary care giver?	
	.....	
7	Has the nature of your illness been explained to you ?	
	a) Yes	☐
	b) No	
8	If 'Yes' to number 7, who explained it to you?	
	a) Doctor	
	b) Nurse	☐
	c) Physiotherapist	
	d) Others - specify	

9	Was any family member present at the time of explanation?	for official use only
	a) Yes	☐
	b) No	
10	If 'Yes' to number 9, is it the same person caring for you now?	
	a) Yes	☐
	b) No	
11	Were you satisfied with the information given?	
	a) Yes	☐
	b) No	
12	If 'No' to number 11, the reasons are:	
	a) Time too short	
	b) Information too complex	
	c) Information inadequate	☐
	d) Only told once	
	e) Other - specify	
13	What instructions were you asked to follow at home?	
	a)	
	b)	
	c)	
	d)	
	e)	
14	If you were given instructions, what observations can you make about them?	
	a) They are easy to follow	
	b) They are difficult to follow	☐
	c) They are very easy to follow	
	d) They are very difficult to follow	
15	If you have any problems about your home care currently, which ones do you consider major? Put them in order of priority.	
	a)	
	b)	
	c)	
	d)	

16	What should health personnel do to help with your home care? ..... Thank you	for official use only

The University of Zambia
School of Medicine,
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA.

18th Jully, 1990

The Medical Officer-in-Charge
Arackan Barracks Camp Clinic,
Box 31931
LUSAKA.

u.f.s. The Head
Department of Post Basic Nursing
Box 50110
LUSAKA.

Dear Sir,

RESEARCH PROJECT

I am 4th year student doing a Bachelor of Science Degree in Nursing. In parttial fulfillment of the requirements for my study, I am required to conduct a research study in the course NR 420 (Nursing Research). My topic of study is - STROKE: An investigative study into the problems stroke patients have after discharge from hospital.

I would be most grateful if you could allow me to interview one patient in B company together with his primary carer.

Yours faithfully,

Cathrine Chilufya (Miss)

The University of Zambia,
Dept. of Post-Basic Nursing,
School of Medicine,
P.O. Box 50110,
Lusaka.

19th July, 1990.

The Ward Chairman of:
Kanyama Compound,
George Compound,
Mandevu Compound,
Mtendere Compound,
Howard Compound,
Kalingalinga Compound,
Ridgeway Residential Area,
Kabwata Compound,
Emmasdale.

u.f.s.

The Head,
Post-Basic Nursing Dept,
UNZA School of Medicine.

Dear Sir,

re: RESEARCH PROJECT

I am a student at the above mentioned school doing the 4th year in Bachelor of Science in Nursing. As part of the requirement to complete the training I have to carry out a research study.

The topic of my study is - STROKE: an investigative study into the problems stroke patients have after discharge from hospital. To complete this study I have to interview some stroke patients and their carers in the above named compounds.

I write, therefore to ask for permission to conduct these interviews in your respective areas.

Yours faithfully,

CAtherine Chilufya (Miss)

Department of Post-Basic Nursing,
University of Zambia,
School of Medicine,
P.O. Box 50110,
Lusaka.

The Officer in Charge,
Sikanze Police Camp,
Lusaka.

19th July, 1990.

u.f.s. The Head,
Post-Basic Nursing Dept.,
School of Medicine.

Dear Sir,

re: RESEARCH PROJECT

I am a 4th year student at the University of Zambia pursuing studies for the Bachelor of Science in Nursing. As part of the course requirements, I am required to carry out a research study. The topic of my study is - STROKE: an investigative study into the problems stroke patients have after discharge from hospital.

I would be grateful therefore if you could allow me to interview one stroke patient in your camp.

Yours faithfully,

Catherine Chilufya (Miss),

Camp Commandant acknowledges and authorised miss Catherine Chibuluya to see her Patient Mr Kali.