

The impact of an information pack on patients with stroke and their carers: a randomized controlled trial

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Objectives: To assess the impact of information packs on patients with stroke and their carers, and to pilot some of the methodology for a trial of a Family Support Organiser (FSO).

Subjects: Seventy-one patients admitted to Oxford hospitals with acute stroke during February-July 1995, and 49 informal carers of these patients.

Design: Randomized controlled trial. Intervention group received an information pack containing various Stroke Association publications one month after their stroke, or at discharge from hospital, whichever was sooner. Control group received nothing. Follow-up was by interview at the place of residence of the patients six months after their stroke.

Measures: Outcome measures assessed knowledge about stroke; satisfaction with information received; patient behaviour in terms of access to community services and benefits; and health status and quality of life.

Results: Patients and carers in the intervention group tended to know more about stroke, but these differences were not significant once adjusted for age. Patients in the intervention group (but not carers) tended to be more satisfied with the information that they had received, but the differences were not significant. There were no differences with regard to any aspects of quality of life in patients in the intervention group, though carers in the intervention group were found to have significantly better mental health ($p = 0.04$).

Conclusions: While the study was too small to generate firm conclusions, information leaflets may lead to improved knowledge about stroke several months after they have been distributed. This finding is worth following up with larger studies. The stroke knowledge questionnaire that was piloted in this trial seems to be able to detect differences between groups.

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Introduction

It is recognized that patients with stroke and their families can experience considerable problems after discharge from hospital, and that formal community health and social services may not address these difficulties adequately.¹ However, there is some controversy over what is the best way of meeting these needs. For example, an evaluation of a stroke family care worker in Edinburgh found that while patients and carers who had received the service were generally more satisfied with the care that they received, there was the suggestion that there may have been adverse psychological effects on patients.²

A randomized controlled trial is currently being carried out to look at the effect of a Stroke Association Family Support Organiser (FSO) in Oxfordshire. One component of the service provided by the FSO is the provision of information leaflets about stroke. Several surveys have identified information as an important need for stroke patients and their carers.³⁻⁶ Some of the methods for the FSO trial were piloted in a small study which looked at the impact of information leaflets alone on patients with stroke and their carers. The results of this pilot study are reported here. A specific question addressed was whether provision of information leaflets had any impact on patients with stroke and their carers.

Methods

Patients

All Oxfordshire residents admitted to Oxford hospitals with acute stroke, or who suffered an acute stroke while an inpatient, between 1 February and 31 July 1995 were eligible for the study. Such patients were identified prospectively for the Oxford Stroke Register (OSR). Patients with possible stroke were reviewed by a senior clinician (consultant or senior registrar) to verify the diagnosis using a widely accepted case definition.^{7,8} Recurrent stroke was included, but subdural haemorrhage, subarachnoid haemorrhage when there was no accompanying intracerebral haemorrhage, and transient ischaemic attack were excluded. Patients were excluded from the study when:

- identification for OSR occurred over one month after stroke;
- death occurred within one month of admission, or was considered likely to occur prior to follow-up;
- they were taking part in another trial involving follow-up interviews;
- they were dysphasic with no close informal carer;
- stroke was not their major medical problem; or
- they were admitted from a nursing home.

Randomization

Randomization was performed by telephone in computer-generated blocks of ten using sequentially numbered opaque envelopes. Patients were randomized either at discharge from hospital, or one month after the stroke (if still an inpatient), whichever was the sooner. Patients and carers were informed in writing about the study and were invited to contact the researchers if they did not wish to take part. The study was approved by the local research ethics committee.

Intervention

A collection of eight leaflets published by the Stroke Association was assembled in an A5 folder. These leaflets describe what a stroke is, what its effects are, what it is caused by, and what specific problems might be experienced and how they might be dealt with. An introductory leaflet was specifically prepared (by JC) together with leaflets giving local and national contact names and addresses of support groups and services which might be of help (see Appendix 1 for further details). Patients in the intervention group were sent the information packs at their home address one week after randomization. Each pack was addressed to both patient and carer (where applicable). Thus, if a patient was still in hospital at the time the pack was sent, the carer would have received it first.

Follow-up

Patients and their closest informal carer, if they had one, were visited at home six months after their stroke. The closest carer was defined as the person perceived by the patient or family as ordinarily being most responsible for day-to-

day decision-making and provision of care. The outcome measures used aimed to assess whether the information packs affected (a) knowledge about stroke and satisfaction with information received; (b) patient behaviour in terms of access to community services and benefits; and (c) health status and quality of life. These outcomes were assessed by means of interviewer-administered questionnaires. A questionnaire was developed specifically for this study to assess patients' and carers' knowledge about stroke and available services (see Appendix 2). Knowledge was assessed by means of a short multiple choice exercise which was based on information that was available in the information pack. Otherwise, previously validated questionnaires were employed: patient⁹ and carer satisfaction questionnaires,¹⁰ the London Handicap Scale,¹¹ the Hospital Anxiety and Depression Scale¹² and the Dartmouth Coop Chart¹³ for the patient, and the Carer Strain Index¹⁴ and the Short-Form 36 (SF-36) for the carers.¹⁵ The Barthel Index was used to assess disability.¹⁶ The interviewer was unaware of whether the patients were in the intervention or control group. To assess the extent to which this 'blinding' was maintained, the interviewer recorded at the end of the visit whether she thought the patient was in the intervention or control group.

Analysis

For dichotomous outcome variables, the Mantel-Haenszel estimates of the odds ratio¹⁷ comparing intervention to control group were calculated. For other outcome variables, statistical significance of differences between intervention and control groups was evaluated using the Mann-Whitney *U*-test.¹⁸ All analyses were performed on the basis of 'intention to treat'.

Results

The flow of patients through the study is summarized in Figure 1. Six patients out of 48 in the intervention group were still in hospital at the time the information pack was posted. Seventy-one patients were followed up. Potential carers were identified for 56 of these patients and 49

were followed up. Seven carers were not available when the interviews with patients were carried out. Questionnaires were not fully completed on all these patients and carers, mostly because of communication difficulties. At the end of the interview, patients ($n = 56$) and carers ($n = 44$) who had been able to complete most of the questionnaires were asked whether they recognized the stroke information pack. Twenty-four of 31 (77%) patients and 21 of 28 (75%) carers in the intervention group and no-one in the control group (25 patients and 16 carers) recognized it. The interviewer correctly identified the status of the patients (intervention or control) in 44 out of 71 cases (62%, 95% confidence interval: 51–73%).

Baseline characteristics

With the exception of age (intervention patients were younger $p = 0.024$), the characteristics of the intervention and control groups were broadly similar (Table 1). More patients in the intervention group than the control group had potential carers (not significant: chi-square 2.65, $p = 0.10$). Thirty-seven (76%) of the carers were married to the patient, and seven (14%) were children of the patient. The remaining five were daughters-in-law ($n = 2$), neighbour ($n = 1$), niece ($n = 1$) or sister ($n = 1$). The relationships of patient to carer was similar in the intervention and control groups. The mean age of carers was 61 years in the intervention group and 64 in the control group.

Outcomes

Knowledge about stroke and satisfaction with information received

Fifty-seven knowledge questionnaires were completed by patients and 39 by carers. Patients in the intervention group did significantly better than controls with regard to two of the questions (2 and 8 – see Table 2 and Appendix 2), and the carers in the intervention group with regard to one of the questions (5). However, only one of these differences remained statistically significant once they had been adjusted for age (Table 2). This adjustment was necessary since patients and carers in the intervention group were younger than those in the control group, and younger people tended to show greater knowledge about

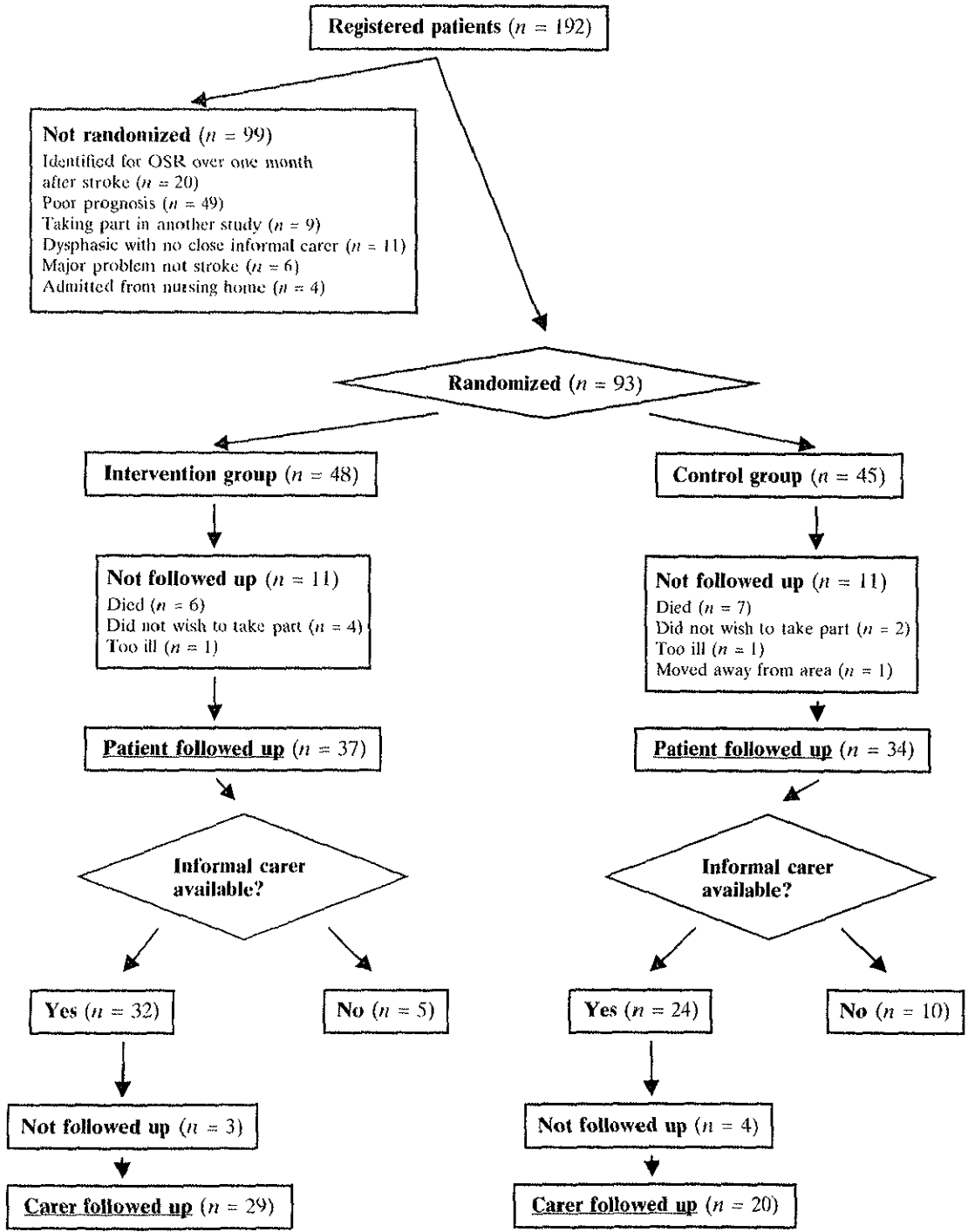


Figure 1 Flow chart of patients through study.

Table 1 Comparison of intervention and control group

	Intervention group (n = 37)		Control group (n = 34)	
		(%)		(%)
<i>Characteristics on admission to hospital</i>				
Sex (male)	24	(65)	22	(65)
Previous stroke or transient ischaemic attack	16	(43)	14	(41)
Dysphasic	13	(35)	13	(38)
Potential carer available	32	(86)	24	(71)
Age (mean; standard deviation)	70	11	76	10
<i>Features of hospital admission</i>				
Admitted to stroke unit	5	(14)	9	(27)
Length of stay in days (median; interquartile range)	21	11-56	26	10-51
<i>Characteristics at follow-up</i>				
Barthel (median; interquartile range)	17	13-20	17	13-19
Living at home	33	(89)	28	(82)

Data complete, except for length of stay, which is based on 65 cases.

Table 2 Odds ratios of correct response to questions about stroke in intervention group as compared to control group

Question	Patient				Carer			
	Odds ratio			% correct ^a	Odds ratio			% correct ^a
	Crude	Adjusted	(95% CI)		Crude	Adjusted	(95% CI)	
1	2.2	2.0	(0.4-10.1)	86	0.8	0.3	(0.0-5.5)	87
2	3.3*	2.9*	(1.0-8.6)	58	1.5	1.5	(0.3-6.6)	69
3	1.9	1.5	(0.5-4.5)	75	1.4	0.7	(0.1-4.6)	85
4	0.7	0.6	(0.2-2.0)	33	0.4	0.2	(0.0-1.3)	59
5	1.8	1.4	(0.4-4.4)	54	6.4*	4.0	(0.8-21.1)	64
6	1.3	1.0	(0.3-3.2)	68	4.2	2.2	(0.3-14.8)	82
7	2.6	2.7	(0.4-17.8)	89	1.3	1.2	(0.1-10.1)	95
8	3.4*	3.0	(0.9-9.4)	61	1.4	1.3	(0.3-6.0)	62
9	0.9	0.7	(0.1-3.2)	88	1.2	1.2	(0.1-10.2)	95
10	0.6	0.6	(0.1-1.9)	70	1.9	1.7	(0.3-10.6)	81
11	2.1	2.0	(0.7-6.1)	63	1.0	1.1	(0.3-4.2)	50

^a Combining intervention and control group.

Adjusted odds ratios give Mantel-Haenszel estimate controlling for age (two groups: 0-69 and 70+).

95% CI = 95% confidence interval of adjusted odds ratio.

*Odds ratio significantly greater than 1 ($p < 0.05$).

stroke. This is reflected in the fact that in most cases in Table 2, the adjusted odds ratios are lower than the crude odds ratios. Nevertheless, after adjustment for age, patients and carers who received the information pack scored better in seven out of ten questions, and worse in only two out of ten. The question about family history (4) was the one which patients and carers as a whole were most likely to get wrong. This was also the

question where the intervention group fared worst.

There were no significant differences in satisfaction with information received between the intervention and the control group (Table 3). Patients in the intervention group tended to be more satisfied than controls, but there was no discernible increase in satisfaction among carers in the intervention group. With regard to informa-

Table 3 Odds ratios (OR) of answering yes to questions concerning satisfaction with information received in intervention group as compared to control group

	Patient		Carer		Combined and adjusted ^c		% answering yes ^b	
	OR ^a	95% CI	OR ^a	95% CI	OR	95% CI	Patient	Carer
A) Do you feel you know enough about what a stroke is?	2.9	0.9-8.9	0.8	0.2-3.1	1.6	0.7-3.7	60	56
B) Would you like more information about the causes of stroke?	0.6	0.2-1.6	0.9	0.3-3.4	0.6	0.3-1.3	42	46
C) Would you like more information about preventing another stroke?	0.5	0.3-2.4	2.0	0.5-7.4	0.8	0.4-1.7	46	56
D) I have been given all the information I want about the causes and nature of my illness	3.0	0.9-9.6	NA	NA	2.5	0.9-6.5	66	
E) I was given all the information I needed about allowances and services after I/my relative left hospital	0.5	0.1-2.0	0.6	0.1-2.4	0.6	0.2-1.6	77	74

^a Unadjusted; 95% CI = 95% confidence interval.

^b Combining intervention and control group.

^c Mantel-Haenszel estimate of odds ratio controlling for status of respondent (patient or carer) and age (two groups: 0-69 and 70+) for A, B, C, E, or age alone for D. NA, not applicable.

tion about allowances, both patients and carers in the control group were more satisfied, but the differences were not significant. In general, ignoring whether or not information packs had been received, carers appeared to know more about stroke, and to be less satisfied with the information that they had received.

Patient behaviour

Data on patient behaviour was obtained for 67 families. Patients in the intervention group saw on average more different types of health professional (mean 4, median 3) than those in the control group (mean 3, median 2) (not significant, $p = 0.08$, Mann-Whitney U). There was no difference in types of contact with support groups and healthcare facilities, and no difference in receipt of benefits. There were no significant differences in contact with any particular type of healthcare professional or type of support group/healthcare facility. Thirty-one of 67 (46%) families were receiving either attendance allowance or disability living allowance, and 23/67 (34%) of families had an orange badge for their car.

Health status and quality of life

There were no significant differences with regard to anxiety, depression, handicap or any dimensions of quality of life between patients in the intervention and the control group (Table 4). There was no difference in caregiver strain, but carers in the intervention group tended to score better on the SF-36. Indeed, for one dimension (mental health), statistical significance was achieved.

Discussion

This was a small study which found no significant effect of information packs on patients' and carers' knowledge about stroke or satisfaction with information received once the results had been adjusted for age (with the exception of one item of knowledge out of 11 questions put to patients). Nevertheless, while not significant, most of the differences were in the direction that one would expect if the information packs were leading to better knowledge. The question asking about whether family history of stroke might be impor-

Table 4 Health status and quality of life of patients and carers

	Possible range of scores	Median scores and interquartile range (IQR)				No.
		Intervention	IQR	Control	IQR	
<i>Patients</i>						
Hospital Anxiety subscale (higher score = more anxious)	0-21	4	1-10	3	2-6.5	54
Hospital Depression subscale (higher score = more depressed)	0-21	4	2-9	5	3-7	54
London Handicap scale (higher score = less handicap)	0-1	0.51	0.39-0.75	0.47	0.40-0.59	68
Dartmouth Coop charts (higher score = lower health status)	1-5					
Physical fitness		4	1-3	5	4-5	65
Feelings		2	1-4	2	1-3	65
Daily activities		3	1-4	4	2.5-5	65
Social activities		1	1-4	2	1-4	65
Pain		3	3-4	3	1-4	64
Overall health		3	1-1	3	3-4	65
Social support		1	2-3	2	1-1	65
Quality of life		2	2-3	2	2-3	65
<i>Carers</i>						
Caregiver strain index (higher score = more strain)	0-13	3	0-7	4	2-6	46
SF-36 scores (higher score = higher health status)	0-100					
Physical functioning		75	37.5-100	62.5	30-77.5	48
Physical - role		100	75-100	100	62.5-100	49
Mental - role		100	66.7-100	100	33.3-100	47
Social functioning		100	72.2-100	100	44.4-100	47
Mental health		84	64-88	72*	52-84	45
Energy		57.5	30-75	40	30-60	47
Pain		83.3	53.6-100	66.7	50-94.4	48
Health perception		62	30-87	71	50-79.5	47

Statistical significance tested using Mann-Whitney *U*. All differences not significant at 5% level, except *, where $p = 0.04$.

tant was the only question where people who had received the information pack did appreciably worse than people who hadn't received them. In hindsight, this was a badly worded question where the 'correct' answer is not immediately apparent. This question has been dropped from the questionnaire in the FSO trial. The effects on satisfaction were mixed: patients in the intervention group tended to express greater satisfaction with information received than those in the control group, but the same was not observed for carers.

Given that significant differences were not observed with regard to knowledge, it is not surprising that no differences in patient behaviour

were observed, either in terms of contact made with healthcare professionals or facilities, or receipt of benefits. Similarly, there were no differences in health status and quality of life measures in patients, though carers in the intervention group were apparently enjoying significantly better mental health than those in the control group. Since multiple tests of statistical significance were performed, this can really only be considered a chance finding.

Limitations of the study

There are several limitations of this study which need to be considered when interpreting its results. First, the study was small and there-

fore prone to a type II error. Therefore, the lack of significant differences between intervention and control groups need to be interpreted with caution. The study has not proved that information packs have no effects; it simply has not demonstrated an effect. The confidence intervals in Tables 3 and 4 are wide, and important benefits of information packs cannot be ruled out.

Secondly, the study was not 'double blind'. In that patients and carers could have known whether they were in the intervention or the control group. This should not have affected the validity of the knowledge questionnaire, but might have influenced some of the subjective measures of outcome, such as satisfaction with information received. For example, patients in the control group may have expressed a desire for more information not because they felt they needed it, but because they knew it was potentially available and they had not received it. Therefore, this bias might have led to an overestimate of the difference in satisfaction between the groups. While in theory the interviewer was blinded to the treatment allocation, in practice she guessed the correct status of the patients more often than might be expected by chance. Since the questionnaires were interviewer-administered, it is conceivable that this might have had a small effect on the results.

Thirdly, despite the randomization, the intervention and control groups were not balanced with respect to an important potential confounding factor - age. The results with regard to knowledge and satisfaction with information were adjusted to take account of this, but the effects on health status and quality of life were not. It is possible, for example, that the higher mental health observed in carers in the intervention group simply reflects the younger age of the people they were caring for. It is conceivable in a small study such as this that other potential confounders that were not measured (such as level of education) might also have been unevenly distributed between control and intervention groups.

Fourthly, while most of the outcome measures used were standard instruments, the stroke knowledge questionnaire was a new tool whose reliability and validity has not been formally tested. If the reliability of the questionnaire is

poor, this is likely to result in random misclassification of patient and carer knowledge, which will make a true difference between the intervention and control groups harder to detect. This study has provided some implicit validation of the instrument, in that people who had received information tended to give more correct responses.

Fifthly, given that only three-quarters of patients and carers in the intervention group actually recognized the information pack it is possible that in some cases they did not have access to it. This would have reduced the magnitude of any observed effects.

Finally, everyone in the intervention group received the same information pack. No attempt was made to tailor the information for the individual needs and circumstances of the patient and their carer. There is some evidence from randomized controlled trials of educational interventions in other conditions, such as Parkinson's disease and rheumatoid arthritis, that information that is specifically targeted at the individual can lead to better outcomes in terms of health status and quality of life.^{19,20} It is interesting to speculate whether some types of patient would have been more likely to benefit from the type of information pack sent than others. However, the study was too small to allow any subgroup analyses to explore hypotheses of this sort.

Research findings elsewhere

There have been few randomized controlled trials of giving information in the form of leaflets to patients with stroke and their carers. In a small study in Southampton, patients with stroke were randomly selected to receive a leaflet one to two weeks after admission. One week later, those who had received the leaflet knew more than controls about stroke, but they did not know anything more about benefits that they might be expected to receive once home.²¹ In a further small study, individualized booklets were given to a random half of patients with stroke at the time of their discharge, but no differences were found in social functioning three months later.²²

Conclusions

While too small to generate any firm conclusions, this study suggests that the simple procedure of sending people with stroke information leaflets may lead to improved knowledge about stroke several months after distribution. This finding is worth following up with larger studies which would have sufficient power to ascertain whether improving knowledge had other effects, such as improving access to services or improving some aspects of quality of life. The stroke knowledge questionnaire that was piloted in this trial seems to be able to detect differences between groups, and will be used, with minor modifications, in the FSO trial, for which this study was a pilot.

Acknowledgements

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Appendix 1 - The information pack

This comprised the three locally produced leaflets and a number of Stroke Association publications.

Leaflets

- 1) Introductory leaflet. Prepared by JC. This explains why the information pack has been sent, and describes what it contains.
- 2) Local information leaflet. Prepared by JC. This gives contact telephone numbers for relevant local services. These include: Benefit enquiry line; Carers Centre telephone helpline and drop-in centre; Social Services Home Care and Disability teams; British Red Cross; Orange Badge Scheme; Ring-a-ride; Dialability; the Oxford wheelchair service; Stroke clubs; Speech and language therapy groups; Age Concern; Samaritans; Disability Employment Advisor; Sports & Leisure for the Disabled.
- 3) National Information leaflet. Prepared by JC. Contact telephone numbers of relevant national organizations. These include: the Stroke Association; Action for Dysphasic Adults; Disabled Living Foundation; Talking Newspapers and Magazines; Sexual and Personal Problems of the Disabled; Remap; Disabled Drivers Association; British Gas; British Telecom.

Stroke Association publications

Publications – help and information. List of publications available from the Stroke Association.

- Stroke – questions and answers. Leaflet S1.
- Swallowing difficulties. Leaflet S18.
- Sex after stroke illness. Leaflet S16.
- Stroke and incontinence. Leaflet S13.
- Stroke and wheelchairs. Leaflet S19.
- Cognitive problems following stroke. Leaflet S25.
- Psychological effects of stroke. Leaflet S9.
- Stroke in younger adults. Leaflet S20.

Appendix 2 - Stroke knowledge questionnaire

Knowledge

Read the following statements about stroke. Please tick one box for each question.

	True	False	Don't know
1) A stroke is caused when the blood supply to part of the brain is cut off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) A stroke is caused by a sudden mental shock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) High blood pressure may lead to a stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) A stroke may happen because there is a family history of stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Blood pressure can be lowered by drinking cold drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) You can reduce the chance of having another stroke by taking less exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		True	False	Don't know
Which of these symptoms might someone have following a stroke?				
7)	A weak arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8)	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9)	Poor balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10)	Eyesight problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11)	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do you feel you know enough about what a stroke is?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like more information about the causes of stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like more information about preventing another stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Please state what further information you would like, if any.		

Do you know who to contact for help with bathing?	<input type="checkbox"/>	<input type="checkbox"/>
Who would you contact? (tick one)		
GP		Care assistant
Nurse		Occupational therapist
Social services		Don't know

Do you know who to contact to have hot meals provided?	<input type="checkbox"/>	<input type="checkbox"/>
Who would you contact? (tick one)		
GP		Care assistant
Nurse		Occupational therapist
Social services		Don't know

Access to services

Please state whether you have seen any of the following people since you (or your relative) came home from hospital (either at home or as an outpatient)

	Yes	No	Don't know		Yes	No	Don't know
Health visitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chiropodist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Care assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
District nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physiotherapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupational therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please list: e.g. dietician; dentist; alternative therapists)

Have you (or your relative) had contact with any of the following:

	Yes	No
Stroke clubs	<input type="checkbox"/>	<input type="checkbox"/>
Speech & language groups	<input type="checkbox"/>	<input type="checkbox"/>
Support groups	<input type="checkbox"/>	<input type="checkbox"/>
Day centres	<input type="checkbox"/>	<input type="checkbox"/>
Rehabilitation centres or units	<input type="checkbox"/>	<input type="checkbox"/>
Day hospital or regular attendance as an outpatient	<input type="checkbox"/>	<input type="checkbox"/>
Local clubs for the elderly or disabled	<input type="checkbox"/>	<input type="checkbox"/>
Leisure clubs or sports clubs	<input type="checkbox"/>	<input type="checkbox"/>
Other		

Are you (or your relative) receiving any of these benefits?

	Yes	No	Don't know
Disability living allowance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance allowance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Invalid care allowance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orange badge scheme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other? Please list	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>