Stroke Best Practices for Occupational Therapy: Are We Meeting the Mark?

Ana Petrovic & Sambidha Ghimire, MSc (OT) Candidates, Queen's University Richard Kellowan, BPHE, MSc(OT), PgCert, OT Reg. (Ont.)

Description

- Do OT services at KGH meet Canadian Stroke Best Practices?
 - Nov Dec 2022: Eight week student project auditing SBPs and acute care OT practice.
- Innovative audit tool to evaluate if KGH stroke OT practice captures SBPs.
 - Encompassed SBPs and common OT ax domains common across Ontario stroke hospitals.
 - Format: ease of use, assessment methods, coding / confidentiality, in / exclusion factors, limitations.
 - Student led, preceptor influenced, focus on identifying gaps for quality improvement.
- Results.
 - Thirty charts audited (10 excluded). Measures taken to reduce bias, ensure consistency, etc.
 - Excluded repatriations and palliative patients no direct OT role due to several factors.

Sample Audit Form

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Occupational Therapy Chart Audit of Stroke Best Practices at Kingston General Hospital (November 24, 2022)

OT Stroke Best Practices	() Pt_1	() Pt_2	() Pt _ <u>3</u>	(R)_Pt_4			
48 HRS: Initiate initial ax & DC planning	Yes XNo PAD 6	X Yes No PAD	Yes No PAD 6	Yes XNo PAD4			
72 HRS: Complete ongoing ax & notes	Yes XNo	X Yes No	Yes 🖄	Yes XNo			
72 HRS: Complete AFIM	XYes PT No PAD	XYes OT No PAD	Yes XNo PAD 6	XYesPT No PAD			
Patients (pts) not initially meeting rehab criteria are monitored weekly for rehab readiness.	Yes XNo	Yes No NA-reliab ready	Yes XNo	Yes X No			
OT intervention starts once patient is medically stable.	Yes XNo	Yes XNo	Yes XNo	Yes X No			

			Chart re	view inc	ludes the followin	ng:				
OT Order	XYes	No	XYes	No		X Yes	No	XYes	No	
Activity Order	XYes	No	XYes	No		XYes	No	XYes	No	
BP Order	X Yes	No	Yes	X No		Yes	XNo	Yes	×No	
O2 Order	XYes	No	XYes	No	1	XYes	No	XYes	No	
tNK / tPA	X Yes	No	Yes	XNo		XYes	No	XYes	No	
EVT	XYes	No	Yes	XNo	1	Yes	XNo	XYes	No	
NIHSS (48 hours)	XYes	No N/A	XYes	No	N/A	XYes	No N/A	XYes	No	N/A
Imaging	XYes	No	XYes	No		XYes	No	XYes	No	
MSK		() Pt _1_		()P	t_2		() Pt 3		(R)I	Pt 4
Hand dominance	XYes	No	XYes	No		×Yes	No	XYes	No	
Pain (U/E and shoulder)	XYes	No Std Ax?NO	XYes	No	Std Ax?	XYes	No Std Ax?	Yes	No	Std Ax?
Skin				20.5						
 Pressure injuries 		No Std Ax?	Yes	XNo	Std Ax?	Yes	No Std Ax?	Yes	×No	Std Ax?
• Edema	Yes	XNo Std Ax?	Yes	KNo	Std Ax?	Yes	≻ No Std Ax?	× Yes	No	Std Ax? NO
Sensation										
Hot / cold	Yes	XNo Std Ax?	Yes	XNo	Std Ax?	Yes	≫No Std Ax?	Yes	×No	Std Ax?
Extinction	XYes	No Std Ax?	Yes	X No	Std Ax?	XYes	No Std Ax?	Yes	× No	Std Ax?
Pain	Yes >	No Std Ax?	Yes	X No	Std Ax?	Yes	XNo Std Ax?	Yes	X No	Std Ax?
 Light touch 	X Yes	No Std Ax?NO	Yes	XNO	Std Ax?	XYes	No Std Ax?	Yes	× No	Std Ax?
 Hyperesthesia 	Yes >	KNO Std Ax?	Yes	XNO	Std Ax?	Yes	No Std Ax?	Yes	× No	Std Ax?
Positioning / Joint protection										
 Assessment 	Yes >	K No	Yes	XNo		Yes	×No	Yes	XNo	
 Intervention (aids / equipment) 		XNO N/A	Yes	X No		Yes	X NO NIA	Yes	XNo	
Tone	Yes ?	No Std Ax?	Yes	XNo	Std Ax?	Yes	XNo Std Ax?	X Yes	No	Std Ax? NO-informal
U/E ROM	222									
 Shoulder (flex/ext, abd/add, IR/ER) 	X Yes	No	_ Yes	X No >	1	_ Yes	XNO 7	L'Yes	× No -)
 Elbow (flcx/cxt) 	XYes	No	Yes	XNo	Solefferved to PT	Yes	XNO (Deferred to	Yes	X No	/
 Wrist (flex/ext) 	XYes	No	Yes	XNo	1	Yes	X No FRE	Yes	× No	
 Digits (flex/ext, abd/add) 	X Yes	No	Yes	XNo)	Yes	×No J T	Yes	× No	further dx to
MMT						1			20040	S forlow + deper
 Shoulder (flex/ext, abd/add, IR/ER) 	XYes	No	Yes	XNO	lin in or	Yes	X'No 7	Yes	X No	to PT notes
 Elbow (flex/ext) 	XYes	No	Yes	XN0 \$	pleferred to PT	Yes	XNO Deferced to	Yes	× No	
 Wrist (flex/ext) 	XYes	No	Yes	XNo)	Yes	XNO XNO XNO	Yes	≺ No	
 Digits (flex/ext, abd/add) 	XYes	No	Yes	X No -		Yes	× No \ Y	Yes	× No]
Bilateral grip	XYes	No	XYes	No		XYes	🛪 No 🚽	Yes	🗴 No)

P a g c 1/6 | Petrovic A., Ghimire S., & Kellowan R. (Nov 24, 2022).

O = observation, C = chart review, P = patient report, A = assessed U = UNKNOWA

Key Findings

Consistent	Mostly	Rarely	Never
(≥ 75%)	(50-74%)	(1- 49%)	(0%)
Orders Excluding BP ranges Behaviour Cognition Orientation Communication Receptive and expressive	Orders BP MSK Hand dominance, U/E, shoulder pain Psychosocial Mood & affect Cognition Memory, insight, functional cognition Visual Perceptual Visual fields, scanning, object ID Functional Feeding Education Current status, Activity recommendations, Discharge planning	 FULL MSK Ax - Scored as All or Nothing for the following U/E ROM, pressure injuries, edema, extinction (sensation), pain, light touch, MMT, gross motor (RAMs), FTN, opposition (fine motor), tone, positioning/joint protection, proprioception Fatigue Post - stroke fatigue – focus on cognitive fatigue. Psychosocial History of depression and / or standardized screens Cognition Alertness, attention, executive functioning, praxis Visual - Perceptual Drawing a clock, object discrimination Functional Tasks – Direct assessment Dressing, grooming, bowel/bladder, bathing, oral care, toileting, all functional mobility components Education – Dependent on Discharge Destination Driving, productive roles / leisure, falls, fatigue 	 Sensation Hot / cold, hyperesthesia Cognition Standardized screening tools Visual Perceptual Visual extinction, Copying a diagram, Pouring water into glass Functional Transportation, IADLs, Nutrition Education Sexuality and relationships, Community resources

Key Points – Discussion

1. Acute care SBPs: Specific but not prescriptive?

- Suggests WHAT to assess but not WHO or HOW.
- SBPs for OTs may be more applicable to rehabilitation or community settings.

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• SBPs in acute care are open to clinical interpretation

2. How do OT clinical factors influence SBPs?

- Competing and continuous factors affect individual interventions.
- "One and Done" OT visits.
- We need to use our "OT Eyes" More.
- "Off service" stroke patients may receive less focused interventions.

3. How do patient trajectories influence our SBPs?

- Patient trajectories may change
- Stroke QBPs fall along a continuum \rightarrow
- OTs must "Pass the Baton"

- Discharge plan determine actual OT roles.
- Not all are applicable to acute care.
- Handovers not practical unless protected time.

Key Points – Discussion

4. Who assesses function?

- OTs are THE "experts" in assessing function
- New graduates feel they miss the mark
- Biomedical Model
- Conditional Clinical Reasoning

- Caseload may limit to chart reviews, reports.
- \rightarrow Cycle of Assess and Discharge
- \rightarrow Limits focus on function

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- Focus on safety / discharge planning
- 5. Are we missing the mark for repatriation patients?
 - "Post Code Lottery" for repatriation patients \rightarrow
 - Priority Matrix does not reflect SBPS \rightarrow
- Acute care priorities only \rightarrow limits treatment.
- Exacerbated by pandemic factors
- 6. Are we supporting end of life care for palliative patients?
 - OTs have clear palliative care roles
 - Focus on in hospital end of life care
 - Patient and OT perspectives

- "Early" GoC decision limit OT roles (discharge)
- \rightarrow Contrasts with non stroke patients (home)
- \rightarrow Focus on QoL, occupation, discharge home.

Implications

- Highlighted practice gaps, areas for improvement, and clinical reflection.
- Staffing and caseload factors (pandemic related) influence if we meet SBPs.
- Interdisciplinary teamwork and collaboration support SBPs.
- Bar has been set for OTs to meet SBPs. Goal: Spring Summer 2023.
- Next steps for program development and quality improvement.

"Assessing function in acute care is like catching butterflies in the wind ... We strive to capture the beauty and uniqueness of each stroke patient but sometimes our net falls short."

Acknowledgements and Contact

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- Contact: Richard Kellowan, OT Reg. (Ont.) Richard.Kellowan@Kingstonhsc.ca