OVERVIEW of REHABILITATION PROGRAM at PSFDH

STROKE NETWORK OF SOUTHEASTERN ONTARIO

PRIMARY CARE UPDATE

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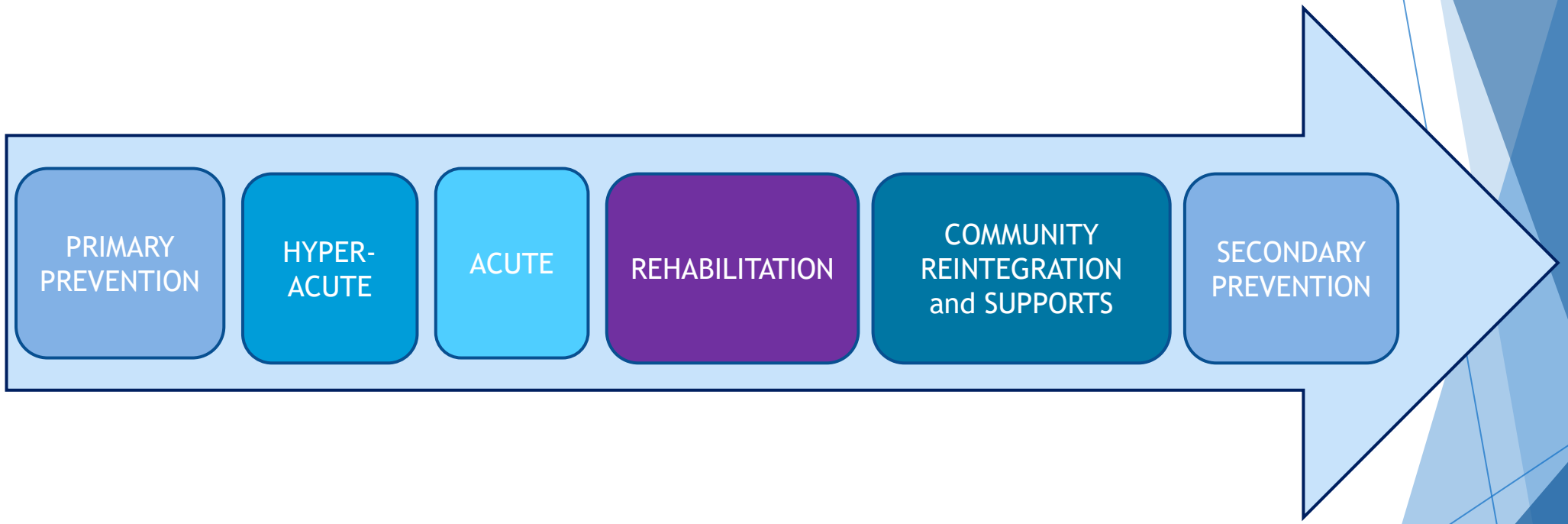
CONTINUUM


PRIMARY PREVENTION
HYPER-ACUTE
ACUTE
REHABILITATION
COMMUNITY REINTEGRATION and SUPPORTS
SECONDARY PREVENTION

OVERVIEW

- Recovery from stroke
- Who we serve
- What we are
- What we do
- Discharge disposition
- Community services
- Transition plan to new model of care

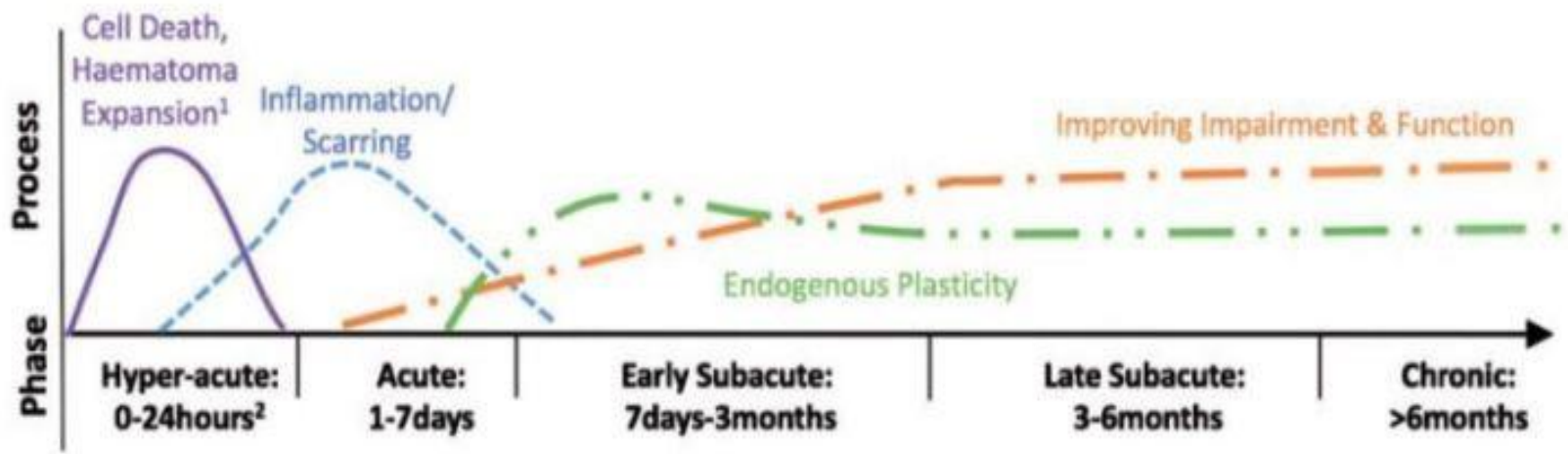
WHAT IS STROKE REHABILITATION?

- The goal of rehabilitation is to restore function as close as possible to prestroke levels or develop compensation strategies to work around a functional impairment.
- Rehabilitation is a process, not a place
- Goal oriented
- Focus on Activities of Daily Living (ADLs), communication, improve cognitive function, Instrumental ADLs, emotional impact on patient and caregiver

Timeline of Stroke Recovery

For more see : https://strokesupport.in/timeline/

Figure 1. Framework that encapsulates definitions of critical timepoints post stroke that link to the currently known biology of recovery.



[1] Haemorrhagic stroke specific. [2] Treatments extend to 24 hours to accommodate options for anterior and posterior circulation, as well as basilar occlusion.

(Taken from : https://journals.sagepub.com/doi/10.1177/1747493017711816)

Recovery

HYPERACUTE :24 HOURS

- Cell death

ACUTE: 1-7 DAYS

- Penumbra
- Spontaneous recovery

Recovery

NEUROPLASTICTY: 7 DAYS-3 MONTHS

- Restore normal function
- Avoid compensation-easy way
- Teach compensatory strategies
- USE IT TO IMPROVE IT!!

NEUROPLASTICITY: 3-6 MONTHS

- End of neural repair
- Marathon not a sprint
- Avoid Compensation-easy way
- Use compensatory strategies
- USE IT TO IMPROVE IT

Recovery

CHRONIC: >6 MONTHS

- USE IT OR LOSE IT
- Compensation-easy way

WHO WE SERVE

TERTIARY HYPERACUTE	ACUTE STROKE UNIT	PSFDH INPATIENTS	COMMUNITY HOSPITALS
KHSC TOH	KHSC TOH BGH	REPAT's INPATIENTS	Kemptville Almonte Carleton Place

WHAT WE ARE

- 6 bed unit
- General Rehabilitation
- Current Model of Care: MRP, Physiatrist, Internal Medicine, others
- Services:
  - *Nursing
  - *Physiotherapy, PTA
  - *Occupational therapy
  - *Speech language pathology
  - *Dietician
  - *Respiratory Therapist
  - *Social Work
  - *Supportive Care
- Teaching Hospital

ADMISSION CRITERIA

- Medically stable
- Require a minimum of 2 therapy services
- Must be able to tolerate a minimum of two 30 minute therapy sessions per day
- Cognitive capacity to be able to follow simple commands, demonstrate ability to learn, demonstrate carry over day to day
- Patient in agreement to participate in the rehab program: i.e.: motivation to improve
- Enteral feeding, foley, trach, O2
- Repatriation agreement in place

- Other: Baseline function, MoCA, alphaFIM

Functional Independence Measure

- Validated measure of Burden of Care
- the amount of time per day in a home situation that an individual requires direct assistance by another person to complete personal care ADL
- 18 Task: self-care, sphincter control, transfers, locomotion, communication, social cognition
- 7 levels: total assistance to complete independence
- Total score 18-156
- Day 3 post stroke: alpha-FIM

FIM

- Average increase in score=25 points
- Predictive value

SCORE DAY 3	LEVEL of ASSISTANCE	HOURS of CARE	SCORE POST REHAB	LEVEL of ASSISTANCE	HOURS of CARE
<30	TOTAL	7-8+	55 (BEST)	MAX-MOD	5-7
40-60	MAX-MOD	4-6	65-85	MOD-MIN	2-4
>80	MIN-SUPERVISION	1-2	105+	SET UP-IND	<1

WHAT WE DO

- Best Practice Guidelines
- Alpha FIM, MoCA, Berg, PHQ-9 etc.
- Patient and family goals and expectations
- Education for patient and family
- Multidisciplinary team meetings
- Pre-discharge home OT assessment
- Patient and family meetings
- Discharge planning-graduated

DISCHARGE DISPOSITION

- Own home-no services
- Home with services/assistive devices
- Accessible home
- Assisted living: Retirement home
- LTC: ALC in hospital to wait.
- Repatriation

DISCHARGE BARRIERS

- Caregiver at home,supports
- Homecare services
- Geography-service areas
- Financial
- PCP

DISCHARGE CHECKLIST

- SECONDARY STROKE PREVENTION: Vascular Protection Clinic
- Follow up tests: 14 day holter, Sleep study
- Medication management
- Safety concerns
- Assistive devices: homecare with professional services, Civitan Club, ADP
- Driving
- Discharge summary to PCP

Community services

- Homecare: PSW, RRN, Nursing, Social Work
- Day Hospital
- Community Stroke Rehabilitation Program

  Community Rehabilitation Planning meeting
- Community Support Services for Stroke
- i-Cart
- Smile
- Senior Support Services

NEW MODE OF CARE FOR INPATIENT REHABILITATION SERVICES at PSFDH

- REHABILITATION NAVIGATOR: Sarah Thompson, senior OT
- MARCH 20
- Assess referrals for the Inpatient Rehabilitation Program to determine suitability for the program.
- PSFDH GENERAL INPATIENT REHABILITATION REFERRAL FORM
- Team Leader
  - Facilitate rounds, family meetings, discharge planning
  - Point person for communication with patient and family
  - Point person for communication with MRP
  - Weekly report and Rehabilitation focused discharge summary to PCP
  - Quality Improvement Metrics
  - Collaborate with Regional Stakeholders as needed to monitor and promote Best Practices for Stroke Rehabilitation at PSFDH


QUESTIONS