South East **LHIN**

Rapid Response Nurse Interventions in a Community Stroke Rehabilitation Program

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Ontario

Faculty/Presenter Disclosure

- Leanna Laing, RN, BScN, NSWOC
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- No disclosures

Pilot Partnership

Stroke Network of Southeastern Ontario: Gwen Brown and Shelley Huffman

Quinte Health Care: Melissa Roblin

Kingston Health Sciences Center: Anne Dube

Brockville General Hospital: Natalie Aitken

Home and Community Care (South East LHIN): Megan Maziarski, Diane Bowen, Laurie French and Leanna Laing

Background-Community Stroke Rehabilitation Program

- Enhanced rehabilitation services for stroke patients in South Eastern Ontario
- Community Stroke Rehabilitation Program (CSRP) services include:
  - Physiotherapy
  - Occupational therapy
  - Speech-language pathology
  - Social work

Background-Acute Stroke Unit

- Patients discharged home from an Acute Stroke Unit (ASU) typically have less severe strokes
- Patients and their families/caregivers often struggle with the initial transition home-following a short stay in hospital
- This indicated a need for an earlier in-home touchpoint with a health care provider
- In response-a pilot was created whereby referrals for Rapid Response Nurses were made in conjunction with the referrals to CSRP

Rapid Response Nurse-RRN

- Direct Care Nursing service
- A Home and Community Care Program within the South East LHIN
- The GOAL for the program is to reduce re-hospitalization and avoidable emergency department visits by improving the quality of transition from acute care to home care by providing transitional support
- A RRN visit occurs within 24-48 hours following hospital discharge including weekends

Program Services – RRN

GOAL: To reduce re-hospitalization and avoidable emergency department visits by improving the quality of transition from acute care to home care by providing transitional support including but not limited to:

- Confirming the patient's hospital discharge care plan including any follow-up appointments, diagnostic testing, etc.
- Initiating communication with primary care provider/specialist physician/pediatrician/other designated provider and arrange follow-up appointment within 7 days of hospital discharge

Program Services - RRN

- Performing thorough medication reconciliation for the patient, consulting with pharmacy/physician/other care provider(s) as needed
- Perform clinical assessment and identify patients requiring accelerated assessment by the care coordinator
- Ensure patient/family is connected with necessary clinical supports, and appropriate resources through assistance with system navigation
- Sharing pertinent assessment findings/potential solutions as appropriate with patient's community care coordinator, primary care provider, etc.

Meet the RRN team:

Diane Bowen

Brooke Fournier

Jennifer Barrie Megan Maziarski

Tammy McEvoy Lindsay Munro

Cindy Moser Darlene McCulloch

CSRP/RRN pilot

- October 2017- March 2019
- 3 consecutive implementation phases
- Each phase included a small project team (RRN, hospital team and the stroke network)
- RRN program and referral processes were reviewed with the key hospital team members at each site
- RRNs were provided with key stroke-related material and education
- Key process metrics were tracked and reviewed regularly be the team

Trial particulars

- 72 patients were referred
- 60% of eligible patients were referred to the RRN program
- 30% of referred patients were not seen

  Reasons:
  - Patient declining service
  - Patient residing outside of Se LHIN region
  - Patient transitioned to LTC

Key Interventions of RRN involvement

1. Medication Reconciliation:

- Resolution of medication discrepancies including follow-up on missing prescriptions, wrong dosages, missing medications as well as directions regarding old/unused medications
- Teaching to reinforce mediation purpose
- Follow-up with pharmacy and prescriber regarding medication dosage questions and/or arrange blister packs
- Completion of medication reconciliation summary
- In two of the phases, medication discrepancies were identified in 40% of patients in the stroke cohort

Key Interventions of RRN involvement

2. Teaching

- Reinforcing the teaching that occurred in hospital (e.g., review of "My Stroke Journey" book)
- Providing information about smoking cessation and local resources
- Formulating safety plans related to mobility and the home environment (e.g., scatter mats and falls risk)

Key Interventions of RRN involvement

3. Liaising with Primary Care Provider

- Completion clinical assessment, with key clinical information sent to the Primary Care Provider
- Assistance to make follow-up PCP appointments and confirm other appointments (e.g., lab work, neurologist, sleep study clinic, pacemaker clinic)

Key Interventions of RRN involvement

4. Providing Patient and Family Support

- Reinforcing teaching to include family given the impact on the entire family and support system
- Answering questions for patient and family
- Discussing community resources
- Facilitating referrals to social work as needed

Pilot Successes

A stroke is a life-changing event for the patient and family. Transitioning home following a stroke is overwhelming for patients and families as they learn to adapt to a “new normal”.

Key successes include:

- Improving linkages to supports and follow-up for patients and families
- Hospital teams received education on the RRN program and referrals processes
- RRNs received Stroke related education and training
- Tracking and regular review of key process metrics to address identified process issues

Conclusion

- RRN interventions improved medication management and linkages to community and primary care services and provided transition support for the patient and family.

- The success of these pilots have resulted in a standard regional referral process to the RRN program for all patients discharged from an Acute Stroke Unit to the Community Stroke Rehab Program.

STROKE NETWORK *of* Southeastern Ontario

TRANSITION TOOLS

Gwen Brown
Regional Community & LTC Coordinator
Stroke Network of Southeastern Ontario

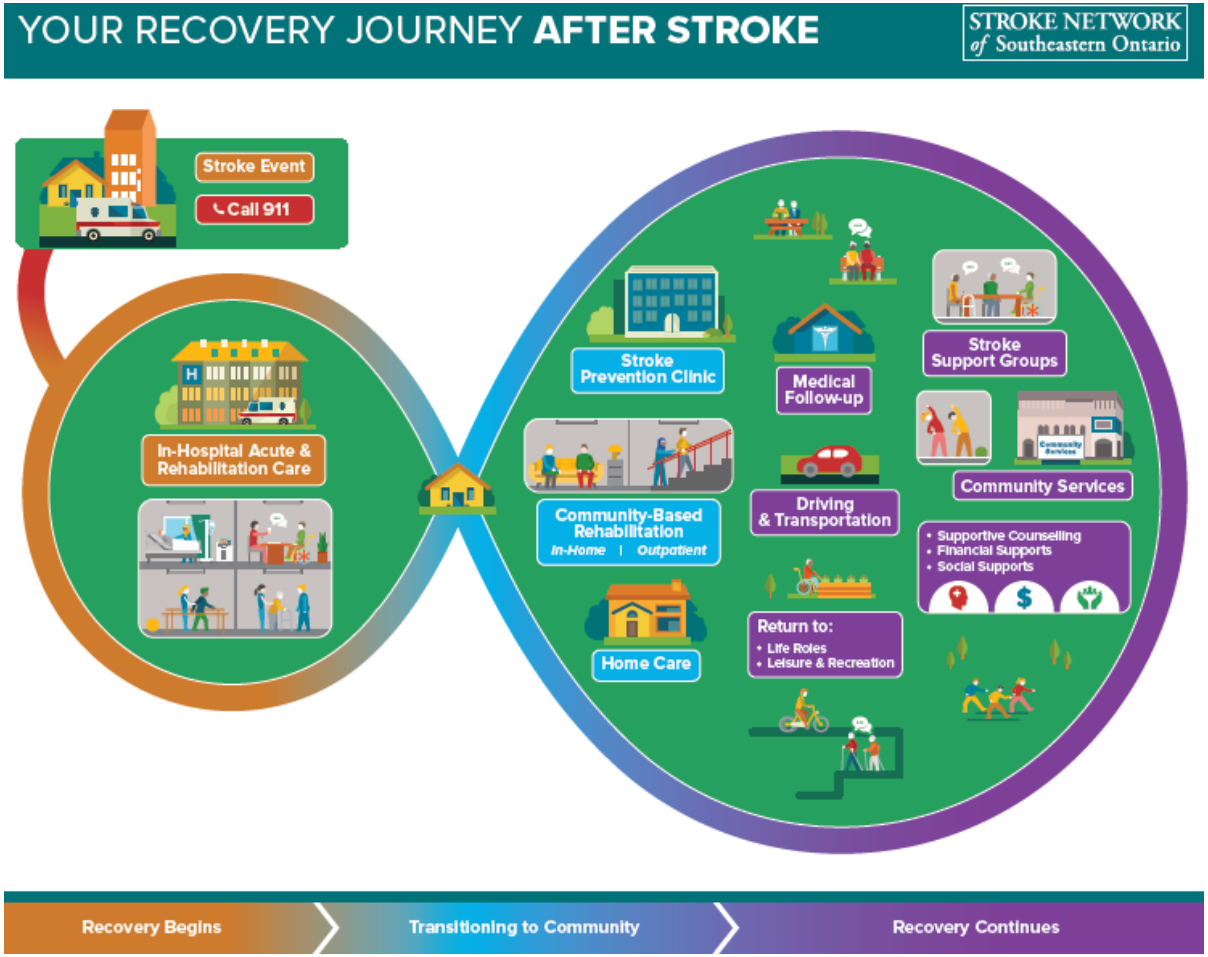
WHAT WE HEARD

- *"One central person to go to is needed, someone to coordinate things and know what's available. You find out by yourself, but it takes a little while. It's frustrating." ~ Stroke Survivor*

- *"He was discharged with one sheet of paper that had his list of medications on it, and that was all. There was no information package. Everything I've tapped into has been through my own research. I have been the one to find and reach out to programs." ~ Caregiver*

- *Stroke survivors need a capable and knowledgeable person to help them navigate the resources available in their communities. It is the old scenario: You do not know what you do not know. This person needs to be a consistent and long term resource to the stroke survivor. Someone that can be a contact even months or years from the time of the stroke, someone to navigate resources when the need exists." ~ Health Care Provider*

PATIENT JOURNEY MAP



PATIENT JOURNEY MAP

YOUR RECOVERY JOURNEY **AFTER STROKE**

As you recover, you may require support from some of the healthcare and community services listed below. These may change over time. Speak to any member of your healthcare team if you have questions or call 310-2222. It is important to remember that everyone's recovery will be different.

Recovery Begins

In-Hospital Acute & Rehabilitation Care

- ☐ Emergency care
- ☐ Acute Stroke Unit care
- ☐ Inpatient rehabilitation
- ☐ Integrated Stroke Unit
- ☐ Complex Continuing Care
- ☐ Other _____

Your Healthcare Team may include:

- ☐ Communicative Disorders Assistant
- ☐ Dietitian
- ☐ Doctor
- ☐ Nurse
- ☐ Nurse Practitioner
- ☐ Occupational Therapist
- ☐ Occupational Therapy Assistant
- ☐ Patient Care Assistant
- ☐ Peer Visitor
- ☐ Personal Support Worker (PSW)
- ☐ Physiotherapist
- ☐ Physiotherapy Assistant
- ☐ Recreation Therapist
- ☐ Social Worker
- ☐ Speech-Language Pathologist
- ☐ Other _____

Notes _____

Transitioning to Community

Stroke Prevention Clinic

- ☐ Stroke specialist doctor
- ☐ Stroke specialist nurse
- ☐ Dietitian
- ☐ Other _____

Community-Based Rehabilitation

- ☐ Outpatient Rehabilitation
  - ☐ Physiotherapist
  - ☐ Occupational Therapist
  - ☐ Speech-Language Pathologist
  - ☐ Other _____
- ☐ In-Home Rehabilitation
  - ☐ Rapid Response Nurse
  - ☐ Occupational Therapist
  - ☐ Physiotherapist
  - ☐ Speech-Language Pathologist
  - ☐ Social Work
  - ☐ Other _____

Home Care

- ☐ Care Coordinator
- ☐ Nurse
- ☐ Personal Support Worker (PSW)
- ☐ Dietitian
- ☐ Meal Delivery
- ☐ Equipment
- ☐ Respite
- ☐ Caregiver Support
- ☐ Other _____

Recovery Continues

Stroke Support Groups

- ☐ Stroke Survivor & Caregiver Groups
- ☐ Aphasia Programs
- ☐ Living with Stroke Programs

Community Services

- ☐ Supportive Counselling
- ☐ Financial Supports
- ☐ Social Supports
  - ☐ Adult Day Programs
  - ☐ Spiritual Supports
  - ☐ Cultural Centres & Supports
- ☐ Other _____

Medical Follow-Up

- ☐ Family doctor
- ☐ Nurse Practitioner
- ☐ Specialist doctor
- ☐ Nurse
- ☐ Physician Assistant
- ☐ Smoking cessation
- ☐ Diabetes Education
- ☐ Other _____

Transportation

- ☐ Return to Driving Programs
- ☐ Accessible Transportation Supports

Return to:

- ☐ Life Roles
- ☐ Work/School Services
- ☐ Volunteering
- ☐ Other _____
- ☐ Leisure & Recreation
  - ☐ Stroke Specific Exercise Programs
  - ☐ Community Exercise Programs
  - ☐ Recreation Programs
  - ☐ Hobbies

STROKE INFORMATION PACKAGE

STROKE NETWORK *of* Southeastern Ontario

INFORMATION ON STROKE FOR PATIENTS & FAMILIES

RESOURCE	DESCRIPTION	WHERE TO ACCESS
Heart & Stroke Publications	Books designed to help stroke survivors and caregivers understand stroke and recovery. • *Your Stroke Journey* • *Taking Charge of Your Stroke Recovery* or the *Post Stroke Checklist* For some clients. It may be appropriate to also provide them with *Stroke in Young Adults.*	www.heartandstroke.com under Health Information Publications
Healthline – Stroke Resources	Bookmark that provides link to this web-based resource. The **Stroke Resources** tab on the Healthline provides information for individuals with stroke and families/caregivers in ten different domains.	Stroke Network of Southeastern Ontario under *Patient Education – Information on Stroke for Patients and Families* Healthline Bookmark
Stroke Support Groups - Regional	Brochure for support groups for individuals with stroke and family/informal caregivers offered in Belleville, Kingston, Brockville and Perth. All groups are free, facilitated by a professional and meet monthly.	Stroke Network of Southeastern Ontario under *Community Supports* Stroke Support Groups
Community-Based Exercise Programs for People with Stroke	Brochure designed for persons with stroke and families to assist them in determining if a community-based exercise program will meet their needs.	Stroke Network of Southeastern Ontario – under *Patient Education – Information on Stroke for Patients and Families* Exercise Brochure
Stroke Specific Exercise Programs	Brochures for community-based exercise programs adapted to the needs of stroke survivors. All programs are free.	Stroke Network of Southeastern Ontario under *Community Supports* Stroke Specific Exercise Programs
Caregiver Support	Family Caregivers Voice is a caregiver-led group that is committed to educating family caregivers on their journey using the invaluable experience of other family caregivers as mentors.	www.familycaregiversvoice.ca Stages of Caregiving Brochure

For stroke survivors with aphasia, please consider including additional resources. Two sites providing free downloadable resources are:
The Aphasia Institute https://www.aphasia.ca/shop/. Navigate to box *If you work or live in Ontario you may be eligible for free downloads of our products.* Complete the form and instructions will be emailed.
Amy's Speech & Language Therapy Inc. http://www.amyspeechlanguagetherapy.com/communication-boards.html
As well, both The Aphasia Institute (Toronto) and The Aphasia Centre (Ottawa) are excellent on-line resources.

YOUR STROKE JOURNEY CHECK-IN – A STROKE SURVIVOR SELF-ASSESSMENT TOOL

STROKE NETWORK *of* Southeastern Ontario

YOUR STROKE JOURNEY CHECK-IN

The following questions are intended to find out how you are doing since your stroke and where you might need some support. It is a self-help questionnaire. Take your time to complete it; you may want to complete the questionnaire over a few days. As well, you may decide to complete the questionnaire at different points during your recovery to check your progress.

When completed, you might want to share the questionnaire with your family doctor, nurse practitioner or other health care provider. If you have answered 'no' to any of the questions, your health care provider can discuss helpful supports.

MY GENERAL HEALTH			
	YES	**NO**	**Not Applicable**
I am satisfied with the amount of assistance that I receive.			
I think I am receiving all the therapy I need (e.g., occupational therapy, physiotherapy, speech therapy, social work).			
I know the signs and symptoms of stroke and the risk factors.			
I understand why I am taking all my **prescription** medications.			
I understand how to take all my **prescription** medications.			
All my questions about the medicines I'm taking have been answered.			
I only purchase medications at one pharmacy.			

COMMUNITY STROKE REHAB PROGRAM

Ontario
South East Local Health Integration Network

STROKE NETWORK *of* Southeastern Ontario

Community Stroke Rehabilitation Program
Information Sheet for Health Care Providers

> *A critical concept within stroke rehabilitation is that 'rehabilitation' does not refer to a specific place or time where care is received. Rather, stroke rehabilitation is a goal-oriented set of therapies and activities as part of patient care post-stroke. Rehabilitation starts shortly after the stroke event occurs and continues as long as required for each individual to achieve their maximum potential recovery.*
> - Canadian Stroke Best Practice Recommendations (2016)

The South East Local Health Integration Networks (LHIN) *Stroke Rehabilitation Program* provides increased intensity of OT, PT, SLP and SW for up to 12 weeks to patients living in the SE region who have experienced a new stroke. Eligible patients are considered for **enhanced Physiotherapy (PT), Occupational Therapy (OT), Social Work (SW) and Speech Language Pathology (SLP)** services through the Home & Community Care offices of the South East LHIN following discharge home. For patients discharged to Long Term Care (LTC), PT will be provided by the LTC Home with enhanced OT, SLP and SW being provided through Home & Community Care. To qualify for the program, patients must be over 16 years of age, have had a recent stroke, and be eligible for therapy from Home & Community Care.

Service Objectives for patients and families include:

- timely access to enhanced community and LTC rehabilitation services;
- improved function;
- the provision of emotional support; and
- improved satisfaction and experience with the transition to home.

The program also supports improved information flow across the continuum of care and enhanced stroke care expertise in the community for health care providers.

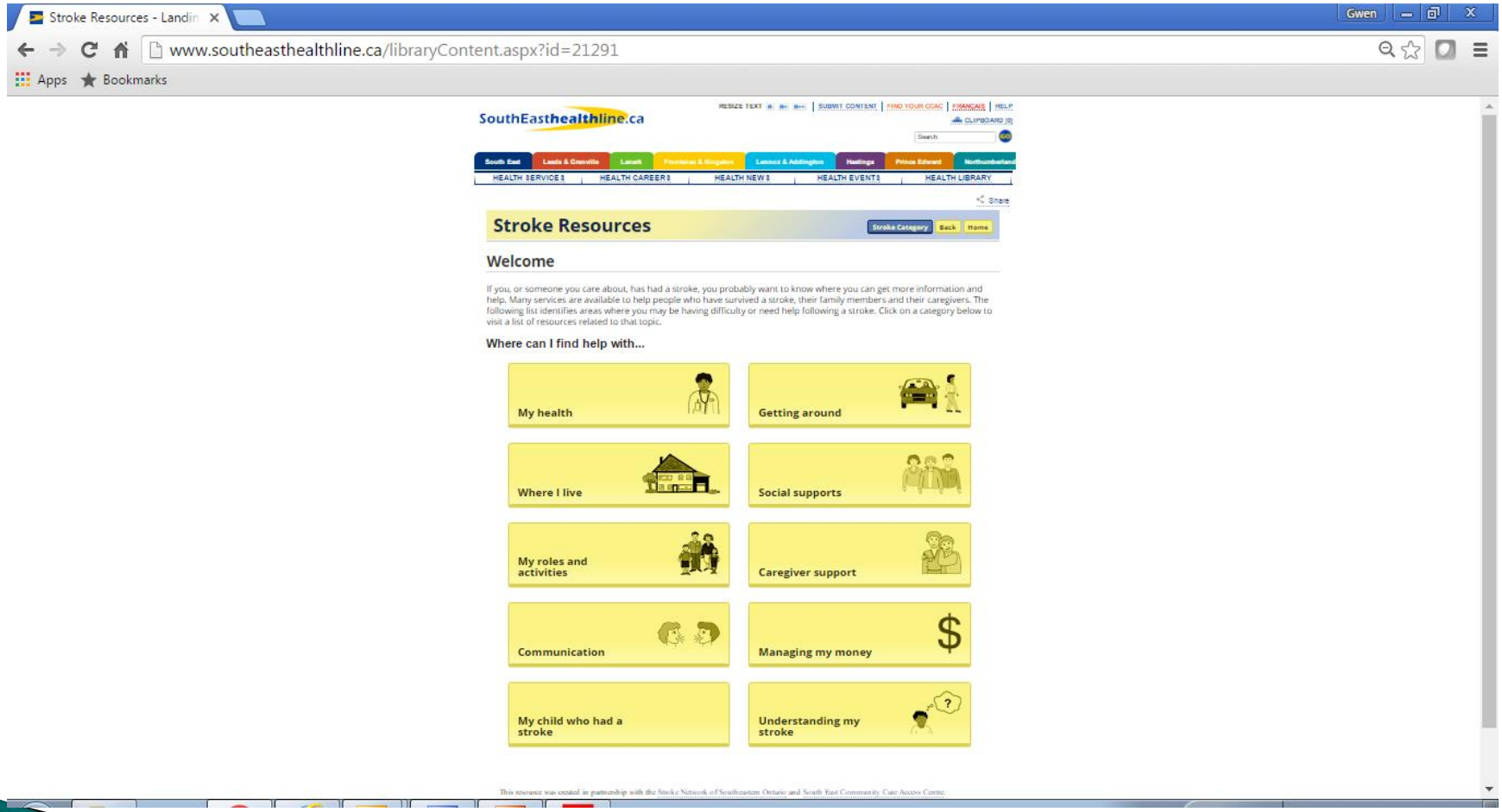
CSRP TRANSITION CHECKLIST

COMMUNITY STROKE REHAB PROGRAM
TRANSITION CHECKLIST –

This checklist will support the identification of and linking to community supports and services following discharge from the Community Stroke Rehab Program. As a global resource, it is recommended that the Stroke Resources microsite on the front page of South East Healthline be shared with the client/family. (www.southeasthealthline.ca)

	Organization	Link
Rehabilitation • Does the client need ongoing rehab services? • Are they eligible for ongoing Home & Community Care services? • Is outpatient rehab an option to meet ongoing needs (are they eligible, is there OP therapy available in the client's area, do they have transportation)?	• Home and Community Care Toll free at 310-2222 • Multidisciplinary Outpatient Rehab Perth 1-613-267-1500 X 2127 Belleville 1-613-969-7400 X 2633 • Outpatient Physiotherapy Kingston – Providence Care Hospital 613-544-490 X 53231	Home and Community Care Perth Outpatient Rehab Belleville Outpatient Rehab Kingston Outpatient Physio
Community Exercise Groups • Could they safely participate in a community program (is there a program available in their area & do they have transportation)? • Is there an opportunity to connect with the exercise provider prior to the client's discharge? • Is there an opportunity for the therapist to attend an exercise class with the client prior to discharge?	• Stroke Specific Exercise Groups (Perth, Belleville, Trenton, Kingston, pending in Brockville) Perth & Brockville 1-800-465-7646 X 2301 Kingston 1-613-634-0130 X 3414 Belleville & Trenton 1-888-279-4866 ext. 5350 • Revved Up (Kingston) 1-613-533-6000 X 79283	Stroke Exercise Groups Revved Up
Returning to Life Roles/Vocations • Is the client considering a return to work or school?	• Stroke Network of Southeastern Ontario 613-549-6666 X 6867 • Community Brain Injury Services 613-547-6969 • Pathways 613-962-2541 • March of Dimes 613-549-4141	Return to Work Toolkit Community Brain Injury Services Pathways March of Dimes

SE HEALTHLINE



STROKE SUPPORT GROUPS

- Inpatient peer visiting
- Pre-discharge consent for follow-up in community by Stroke Support Group Facilitator (navigation support)
- Pre-discharge caregiver linking to support groups

Stroke Support Groups

Aphasia Supports

Stroke Specific Exercise

STROKE NETWORK OF SOUTHEASTERN ONTARIO WEBSITE

- Return to Driving
- Return to Work
- Caregiver Supports
- Stroke Support Groups
- Aphasia Supports
- Stroke Specific Exercise Groups

- *Effective system navigation provides several benefits including "lessening social isolation, supporting care partners and symptom management and decreasing use of both acute and long term care services."* (Montgomery et al, 2015)