Quinte Health Care

Melissa Roblin

Stroke Resource Nurse

Clarifying Needs– Southeastern Ontario Acute Stroke Collaborative

OUR TEAM	
Melissa Roblin	Stroke Resource Nurse
Amy Quilty	OT Inpatient Rehab
Anna Dowling	PT Acute Stroke Unit
Shawn Allen	SLP Acute Stroke Unit
Katie Petherick	PTA Acute Stroke Unit
April Hay	OT Acute Stroke Unit
Kathleen Kramer	RN Emergency Department
Jennifer Belch	RN Emergency Department
Derk Damron	Manager Stroke Program, Therapy
Gen McDonald	RN Professional Practice
Heather Chase	PSW Acute Stroke Unit
Jennifer Edwards	PSW Acute Stroke Unit
Jacquie Curran	RPN Acute Stroke Unit
Sarah Ryckman	RPN Acute Stroke Unit
Stephanie McGowan	RN Acute Stroke Unit
Icel Samarzadeh-Vajehfar	RN Intensive Care Unit

Usual Process: Mobility

- Ensure patient is stable (hemodynamically, neurologically, consideration of 24 hour from onset time window, etc) → Goal to mobilize within 24 hours of admission → OT/PT/SRN initial ax as a team → update whiteboard + team discussion (as possible) → up daily → stretches and exercises → positioning in chair or bed (pillows, HOB) → encouragement → PT/OT/PTA reassess daily → team discussions at stroke rounds daily

How we know this is working well: Mobility

- Patients are:
  - safely mobilizing, have appropriate equipment
  - aware of mobility goals
  - improving in strength, transfers and tolerance
  - up every day, decreased amount of time in bed
- Metrics:
  - pressure ulcer, falls, % of patient's referred to rehab, FIM efficiency rehab

What is working well: Mobility

- Interprofessional approach

  "working as a team to provide care to patients"
- Staff engagement - kudos to our PSWs

  "our staff our diligent about safe/proper positioning, getting up to w/c daily"
- Quick access to OT/PT/PTA/SRN

Usual Process: Dysphagia Screening & Management

- NPO until swallowing assessment → SLP ax often begins in ER → bedside swallowing assessment tool completed (based on the STAND) → SLP formal ax if failed swallowing screening → SLP monitors if passed → modified diet textures→ cookie swallow by SLP (when needed) → 02 monitoring → NG tube or PEG (when needed)

How we know this is working well: Dysphagia Screening & Management

- Patients:
  - have their swallowing screened
  - receive appropriate diet texture
  - are positioned properly for meals
  - tolerate oral intake without aspiration/complication
  - receive adequate nutrition (vitals, lab values within normal limits)
- Team including patient/family aware of SLP recommendations
- Metrics:
  - swallowing assessment tool completion, mortality rate

What is working well: Dysphagia Screening & Management

- Bedside screening can be done by nursing

  "Since SLP are not in on the weekends I can assess ASAP and speak with doctor about alternate route and not have to wait until Monday"
- % of patients screened with swallowing assessment tool is slowly increasing
- Patient's maintained NPO until screening
- SLP assessment often done in ER
- SLP follows all patients for dysphagia
- SLP now Mon-Fri coverage regardless of holidays

Usual Process: Aphasia & Communication

Supportive Communication Strategies implemented i.e. speak slowly, one idea at a time, yes/no questions, time to answer, written, gestures, communication sheets → Independence encouraged, questions directed to patient →Quick access to SLP for consult →SLPs use the Western Aphasia Battery – Bedside Form for initial ax →CDA available to assist (caseload dependent) →Team discussions at daily stroke rounds → Interprofessional approach

How we know this is working well: Aphasia & Communication

- Patient:
  - better able to communicate needs
  - better able to express themselves
  - Less frustrated (and family too)
  - progressing in expression of speech or language comprehension

What is working well: Aphasia & Communication

- Staff aware of/alert to aphasia
- Use of supportive communication strategies
- Team oriented approach to supportive communication

  "if one person is unable to discern what is being communicated, other staff will try"
- Focused on patient + encouraging independence

  "we know you know"

Usual Process: Transitions

Patient/family focused team approach → AlphaFIM triage tool assists in decisions - Home (LHIN or RDH)/CCC/Rehab →Rehab on site →PFC assist with referrals →Phone call between therapists → SBAR to support nursing transitions →SRN follows patient corporately →EMS for transfers to ASU →Transfer service when transferring to CCC

How we know this is working well: Transitions

- Patient and family:
  - involved in decisions
  - in agreement/consent to plan
  - aware of discharge date as soon as possible
- Discharge planning starts right away
- Metrics:
  - LOS, alphaFIM completion, rehab intensity, % of patient's returning to acute care, patient experience surveys

What is working well: Transitions

- All team members involved with transitions (patient, family, physicians, nurses, PSW, PT, OT, PTA, SLP, SRN, patient flow)

  "Working as a team to make the appropriate decisions"
- On site Inpatient Rehabilitation
- AlphaFIM triage tool
- Stroke Resource Nurse role

Challenges

- Some inconsistency with swallowing screening
- Limited SLP resource for Speech & Language
- Limited PT/OT/SLP on weekends (initial ax or repeat ax can be delayed until Monday)
- Shortage of appropriate equipment (wheelchairs)
- Delays in changes to diet consistency
- Limited choices for modified diet textures
- Some inconsistency in transferring techniques or mobilization practices
- Variation in physician practice (MOT letters etc)
- Time to spend with patient
- Ongoing staff education (formal and informal)

Contact for More Information:

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Role on Team: Stroke Resource Nurse

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