Rapid Response Nurse Interventions in a Community Stroke Rehabilitation Program

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Background

- In southeast Ontario, stroke patients discharged from hospital to home are eligible for enhanced rehabilitation services through the South East Local Health Integration Network (LHIN).
- The Community Stroke Rehabilitation Program (CSRP) services include physiotherapy, occupational therapy, speech-language pathology and social work and median wait time to first therapy visit is four days.
- Patients discharged directly home from an Acute Stroke Unit (ASU) typically have less severe strokes. Patients and their caregivers/families often struggle with the initial transition following a short length of stay in hospital indicating a need for an earlier in-home touchpoint with a health care provider (HCP).
- In response, a pilot was initiated whereby referrals to the South East LHIN's Rapid Response Nurse (RRN) program were made in conjunction with referrals to the CSRP. A RRN visit occurs within 24 - 48 hours following hospital discharge including weekends.

Methodology

- Between October 2017 and March 2019, three consecutive implementation phases occurred.
- Each phase included a small project team with representation from the RRN program, hospital team and Stroke Network.
- The RRN program and referral processes were reviewed with key hospital team members at each site.
- RRNs were provided with key stroke-related education materials and were linked to additional resources and/or training as required (e.g., aphasia workshop).
- Key process metrics were tracked and project teams met regularly to review findings and address process issues during implementation.

Findings

- 72 patients were referred.
- 60 per cent of patients received an RRN visit (n=43).
- 30 per cent of patients (n=22) were not seen.
- Reasons for not receiving a RRN visit included: patient declining service, patient residing out of SE region, patient transitioned to long-term care.
- RRN visits resulted in similar key interventions (noted to right).

Key Interventions

Medication Reconciliation

- Resolution of medication discrepancies including follow-up on missing prescriptions, wrong dosages, missing medications as well as directions regarding old/unused medications.
- Follow-up with pharmacy and prescriber regarding medication and dosage questions and/or to arrange blister packs.
- Teaching to reinforce medication purpose.
- Teaching correct inhaler technique.
- Completion of medication reconciliation summary (copy left in home for patient and shared with Primary Care Provider).
- In two pilots, medication discrepancies were identified in 40 per cent of patients in the stroke cohort compared to 26 per cent of patients within the total RRN referrals.

Teaching

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

Liaising with Primary Care Provider

- Completion of six page clinical assessment copy left in the home for patient and family and sent to Primary Care Provider (PCP).
- Assistance to make follow-up PCP appointments and to confirm other appointments (e.g., lab work, neurologist, sleep study clinic, pacemaker clinic).

Providing Family Support

- Reinforcing teaching with family given the impact on the entire family and support system.
- Answering questions for patient and family.
- Discussing community resources (e.g., community support services and transportation services).
- Facilitating referrals to social work as needed.

Discussion

- A stroke is a life-changing event for the patient and family.
- For those individuals being referred to the CSRP, there is usually a new disability.
- Transitioning home following a stroke is overwhelming for patients and families as they learn to adapt to a 'new normal'.
- Key success factors for all pilots included:
  - Improving linkages to supports and follow-up for patients and families
  - Ensuring that hospital teams received education on the RRN program and that they supported the referral process with accurate and timely discharge/medical summaries and medication lists.
  - Provision of select stroke-related education materials and/or training for the RRNs as required.
  - Tracking and regular review of key process metrics to address identified process issues.

Being able to assist patients as they transition back to their homes after a life altering illness is a rewarding and humbling experience. By "connecting the dots" for patients and answering questions within those initial days of hospital discharge, I see the positive influence of this role for patients day after day! ~RRN

Conclusions

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 ASU to the CSRP.