STROKE NETWORK *of* Southeastern Ontario

Acute - Rehab - Community (ARC)

Stroke Services and Transitions

Moving Towards One Team

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“One Team”

The system needs to function as “ONE team” from the patient’s perspective……

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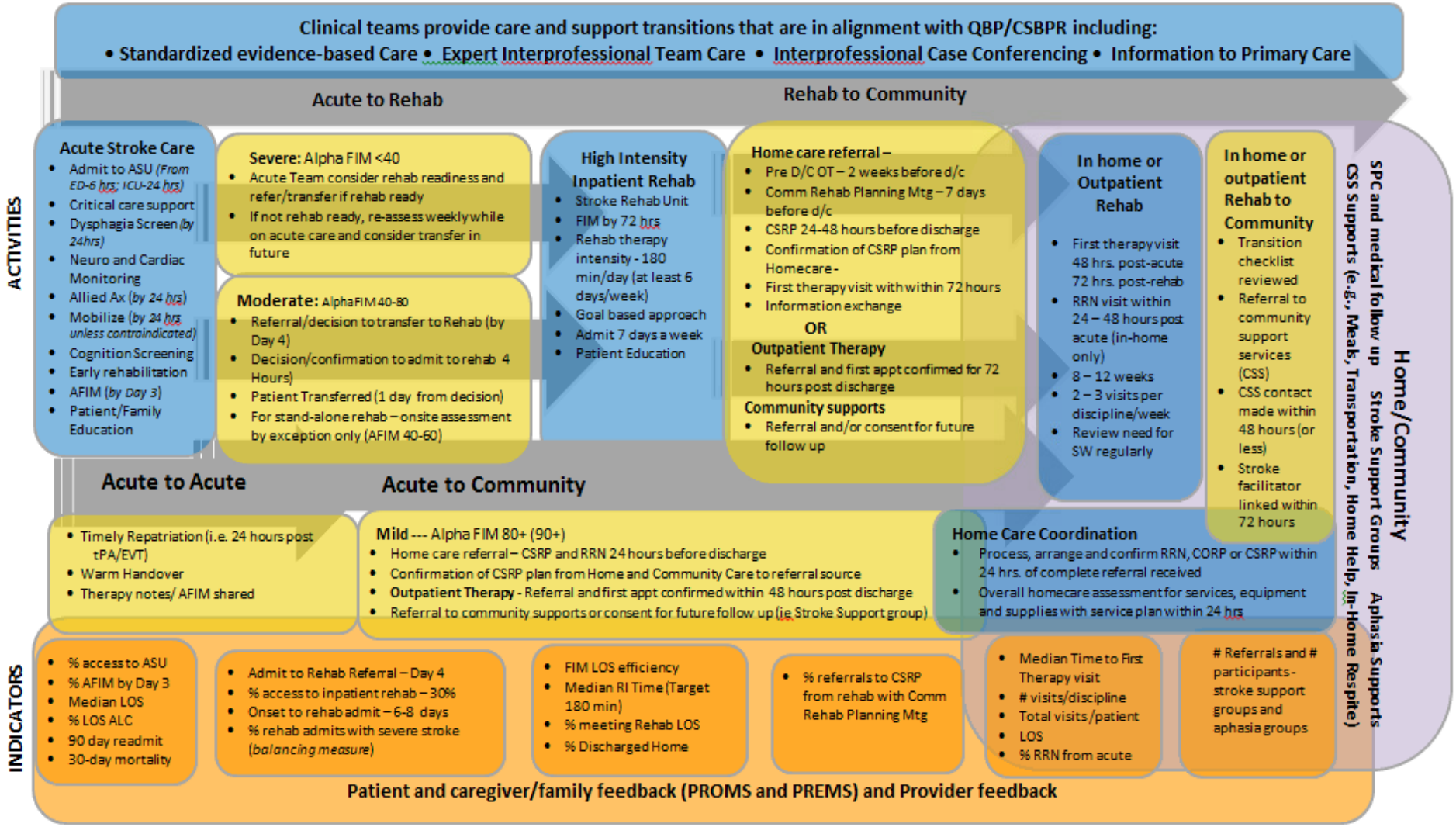
Activities

- ✓SE Stroke Pathway with common components and parameters
- ✓Self-assessment of team core elements within and between teams
- ✓Regional Forum September 2019 – learn and be inspired

Sept 9 2019

Acute - Rehab - Community (ARC) Stroke Services and Transitions



Self Assessments

Included 2 components - core elements within team activities and transition elements

Self-assessments completed with:

- Acute (3 teams), Inpatient Rehab (4 teams), Outpatient Rehab (2 teams), Home and Community Care (LHIN), Community Rehab Providers (3 teams), Community Support Services (3 teams)

Rankings: Complete, Partial or Incomplete on each elements

Examples - within team

Acute Stroke Care – Self-Assessment

ASU	Requirement	Site 1	Site 2	Site 3
1	Acute Stroke Unit (ASU) (Target 80%)	P	C	C
2	CSBPR/QBP recommended treatments/evidence based care	P	C	C
3	Interprofessional team (MD, RN, PT, OT, SLP, RD, SW)	C	I	C
4	Team available 7 days a week (PT, OT, SLP specifically)	I	P	I
5	Critical Care Support available	C	C	C
6	Cardiac Monitoring	C	C	C
7	Diagnostics completed in timely manner	P	C	C
8	Dysphagia Screening	C	C	P
9	Neuro Monitoring	C	C	C
10	Allied Ax - within 24 - 48 hours	P	C	C
11	Mobilization within 24 hours (unless contraindicated)	C	C	C
12	Cognition Screening	C	C	C
13	AFIM by Day 3	P	P	C
14	Early rehabilitation initiated post-assessments	P	C	C
15	Patient/Family Education and Support/Stroke Information Package	C/P	C	P
16	Patient and Family Discharge Communication Process	C	C	C

Examples - Transition

Community Stroke Rehab - Transition to Community Supports - Assessment

	Requirement			
H to CSRP	**Transition from Hospital**	**Team 1**	**Team 2**	**Team 3**
	Accept referrals within 1 hour through Health Partner Gateway with LHIN	C	C	C
	Contact client to arrange visit (within 2 days)	C	C	C
CSRP to Comm	**Transition after Comm Rehab Complete**			
	Referral to community supports – stroke specific (support groups/exercise groups) and generic (meals, transportation, respite, home help etc.)	C	C	P
	Referral to SW has been discussed and referral considered if not yet linked	C	C	P
	Provides written instructions for ongoing maintenance activities to continue recovery	C	C	C
	Confirms patient has Stroke Information Package and able to provide if needed	I	**P**	I
	Return to life roles and recreation is discussed and linkages made as required.	C	C	P
	Consider patient goals and determine if referral to home care rehab or other services as required.'	C	P	C
	Discharge information and recommendations are shared with primary care	I	I	I
	Transition checklist completed	I	**P**	I

Self – Assessment Summary

- Significant **commitment and experience** to provide stroke service and supports across the continuum
- Teams **vary in their access to data** for input into their self-assessments
- **Allied health resources** a challenge across the region
- System (after hyper-acute) functions **5 days/week** impacting response times between transitions
- **Gaps in creating warm hand-offs** and closing the feedback loop between services
- Passion for stroke care across the region – interest in **learning from others**

Regional Event

Goals:

- To share current state of stroke services and transitions
- To identify regional and local opportunities to support clinical implementation of a seamless, high quality patient experience in preparation for bundled funding

Voice of the Stroke Survivor

"Though it is not your first experience working with a stroke survivor/caregiver, it is our first and everything is new, we are anxious and scared. You may need to repeat information several times as we do not always retain what you have said."

"Our situation and support requirements may change over time, we need to be advised on what to do or how to access additional services at a later date."

"Be patient, do not rush…"

Learning about Integrated Stroke Care from Waterloo Wellington

- Integrated planning and system integration across partner sites
- Automatic acceptance pathways to rehab
- Coordinated bed access for rehab beds
- Stroke Navigator role
- Use “bands” of stroke severity to guide pathway
- Community Stroke Rehab – offered as a program of care/pathway model, includes weekend first visit, use of assistants

St. Joseph's Health Centre Guelph
Grand River Hospital Advancing Exceptional Care
Cambridge Memorial Hospital
Guelph General Hospital
St. Mary's General Hospital
North Wellington Health Care
Groves Memorial Community Hospital
March of Dimes Canada
Waterloo Wellington LHIN

Improving Home to Community Transitions… Suggestions

- **Consistent use Stroke Information Package**
  - *Reviewed with a person – not just the "paper"*
  - *Use of transition checklist to ensure it happens*

- **Booking Appointment in next part of the continuum – e.g. SPC, OP therapy**
  - *Record all appointment in one spot*

- **Ensuring appropriate referrals/linkages**
  - *Checklist for referrals made/available to all team*
- **Ensuring next care provider has needed information**
  - *Integrated report for all team members*

What Participants Had to Say….

"Stroke survivor's reminded me that this is their first stroke and so I need to address them, educate them, support them as such. SLOW DOWN!"

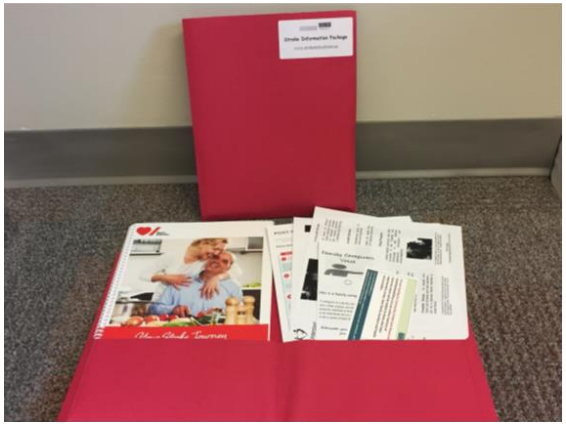
Better communication is required at points of transition; ensuring our patients have the appropriate information at discharge

More of these (sessions) please - where people come from across the numerous phases patient journey. The more we share and know each other - the better the system becomes."

Moving towards “One Team”

Regional support:

- Develop navigation supports/skills
  - Workshop 2020
  - Toolkit
  - Communication guide for providers to explain system elements/transitions to patients
- Spread use of Stroke Information Packages; include patient journey map
- Linkages and learning from others
- Check in and support local action plans for improvement ideas/sharing



Moving towards “One Team”

Local changes:

- Ensuring use of stroke information package prior to hospital discharge
- Spread of consent process for stroke support contact in the community
- Make Use of Patient journey map
- “Fast Track” to improve access to rehabilitation in Kingston
- Improved communication strategies between teams

Building Stronger Links

Share what you or your team/partners are working on!

Moving towards “One Team”

What can I do today…..

- Be patient/slow down when teaching patients about steps in their journey
- Practice “warm hand off” between teams whenever possible
- Set up the next phase of the journey for success by sharing information
- Learn about other parts of the journey to help with navigation

YOUR RECOVERY JOURNEY **AFTER STROKE**

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