STROKE NETWORK *of* Southeastern Ontario

Acute - Rehab - Community (ARC)

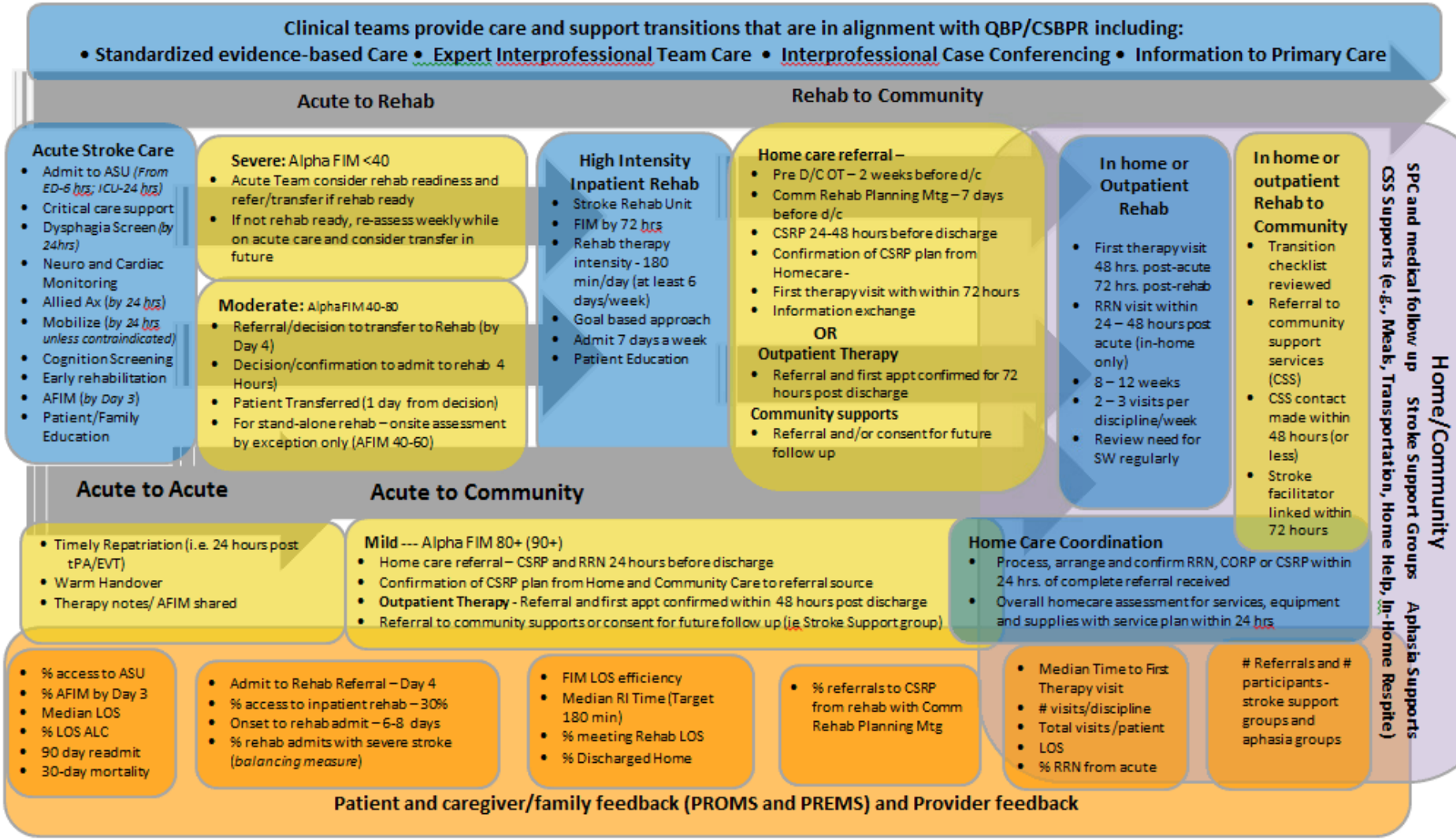
Stroke Services and Transitions Pathway

Self-Assessment – Regional Summary

September 2019

Sept 9 2019

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



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

Acute Stroke Unit - Transitions – Self Assessment

	Requirement	Site 1	Site 2	Site 3
ATC	**Acute to Community (ATC)**			
1	Alpha FIM 80+ - discharge home with CSRP or outpatient - first option	C	C	C
2	Refer to CSRP including RRN / 24 hrs before d/c	P	C	C
3	Link to community supports (stroke support groups, transportation, meals, etc)	I	C	C
4	Written discharge instructions	C	C	C
5	Information is transferred to Primary Care	C	P	C
6	Follow up check in 24-48 hours post discharge (ie follow up phone call)	I	C	I
7	Outpatient therapy appointment booked and communicated prior to discharge	I/NA	P	I/NA
8	Referral made to the Stroke Prevention Clinic on Discharge	C	C	C
9	Diagnostics not completed as an inpatient are arranged for outpatient follow up	C	P	C
ATR	**Acute to Rehab (ATR)**			
1	Alpha FIM 40 – 80 – Referral/Decision to transfer to rehab by Day 4	C	P	C
2	Alpha FIM 0-39 – Assess for rehab readiness and refer to rehab	C	P	C
3	Education with patient and family on rehabilitation	C	C	C
4	Advise patient/family on decision from rehab site	C	C	C
5	Prepare patient for safe transfer	C	C	C
ATA	**Acute to Acute (ATA)**			
1	Repatriate within 24 - 48 hours to local stroke unit	C	P	C
2	Share Alpha FIM if transfer after Day 3	C	C	C
3	Share Allied Health Assessments	P	C	C
4	Warm Hand Over between sites	C	C	C
ALTC	**Acute to LTC (ALTC)**			
1	Refer to CSRP for transition to LTC (refer to at minimum OT)	C	C	C

Transition Tools/Supports

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

PATIENT INFORMATION

Patient Care Order Set

Review Due Date: 2021 October

Acute Stroke and Transient Ischemic Attack (TIA) Discharge and Follow-up QBP Order Set

TRANSCRIPTION

Discharge Date and Disposition

☒ Discharge date: _____(yyyy-mm-

***Consider Inpatient Rehabilitation or Complex Continuing Care for patients with a
less than 40, Inpatient Rehabilitation for patients with early Alpha FIM® score betw
stroke rehabilitation (in-home/outpatient) for patients with early Alpha FIM® scor

☐ Discharge/transfer stable patient to:

☐ Home / Previous place of residence ☐ Long Term Care
☐ Providence Care Hospital ☐ Other _____

Discharge Patient Care

☒ Discontinue IV fluids
☒ Remove IV lines including saline locks unless being transferred to acute
☒ Discontinue telemetry

Diagnostic Investigations Pending/Planned at the time of d

Prescriber to provide new requisitions
Do not need to be transcribed
***Forward the requisitions by Fax/Tube system to the intende

☐ CT Head Non-Contrast at ☐ KHSC (via tube system-15) or ☐ _____
☐ CT Angiography at ☐ KHSC (via tube system-15) or ☐ _____
☐ MRI Head at ☐ KHSC (via tube system-15) or ☐ _____
☐ Carotid Doppler at ☐ KHSC (Fax:613-548-1321) or ☐ _____

Cardiac Testing

***For patients with TIA or embolic stroke without identified etiology where s

1

My Discharge Plan

_____'s Discharge Plan Date of Birth_____

I came to hospital on _____ and lef

I came to hospital because I had a stroke or a transient i

Before I leave the hospital

After talking with my healthcare team, I'll tell them in my own words w
we talked about. This helps to make sure they've covered everything cl
It also helps to explain things that may have been a bit confusing.

Before I go home, I'll make sure I can to do these things:

- I can tell you why I was in the hospital
- I can tell you what I'll do if my symptoms don't get better or co
  back

Medications I need to take

	Yes	N
Did someone go over my medications with me?	☐	☐
Do I understand my medications?	☐	☐

If I said "No" to one of these questions I should talk to a Nurse or Pharmacist before I leave

How I might feel and what to do

How I might feel	What to do
I have new stroke or TIA symptoms: • My face is	**Call 911 right away** **Don't drive to the hospital!**

ACUTE STROKE BEST PRACTICES REMINDER CHECKLIST

Stroke Unit Care Saves Lives

- ☐ **Neuro Assessment: Canadian Neurological Scale (CNS)** is used to compare baseline stroke severity, quantify neurological recovery and identify early deterioration.
- ☐ Administer Tylenol for **temperature** >37.5.
- ☐ Monitor **heart rate and rhythm** - arrhythmia is common.
- ☐ Treat **blood pressure** if above 220/120 for patients NOT receiving tPA, not having hemorrhagic stroke and not accompanied by MI, acute renal failure or aortic dissection.
- ☐ Glucometer checks q4h for 48h if admission **glucose** abnormal, then reassess. Results > 10 or < 4 reported and treated.
- ☐ **Swallowing Function**: Keep patients NPO until STAND or SLP consult is done. **Oral Care** at least twice a day & increase frequency for patients who are NPO.
- ☐ **Assess for Pain**. Shoulder pain is common.
- ☐ **Mobilize** unless contraindicated.
- ☐ **VTE prophylaxis** administered for patients with limited mobility (e.g., SCD or LMWH, fluids, mobilization).
- ☐ **Hydrate**- ensure IV in place if patient is NPO.
- ☐ **Bowel management**. Assess for constipation. Provide laxatives prn.
- ☐ **Avoid indwelling urinary foley catheter**. If clinically needed, reassess within 24h for removal.
- ☐ **Contact Your Acute Interprofessional Stroke Team.**
- ☐ **Provide patient & family education and support** including discharge planning (e.g., patients prescribed an oral anticoagulant should be educated regarding importance of daily adherence & dangers of missed doses).

- ✓ Stroke Survivor & Caregiver Support Groups have expanded across region (including Aphasia Conversation Groups)
- ✓ Community Stroke Rehabilitation Program Updated
- ✓ Hospitals following health literacy principles & providing Patient Oriented Discharge Plans
- ✓ Discharge order set developed
- ✓ Standard Stroke Information Package compiled. Packages located in the Stroke Unit. When the time is right, patients and families are provided with the Stroke Information Package. Packages contain these core materials:
  - Your Stroke Journey
  - Bookmark directing patients to SouthEasthealthline.ca Website containing many community stroke resources and services
  - Stroke Survivor Group brochure
  - Community Stroke Exercise Program flyer (if available)
  - Caregiver resource

Information can always be added to the package depending on patient and family needs.

High Intensity Inpatient Rehabilitation – Self Assessment

Inpt Rehab	Requirement	Site 1	Site 2	Site 3	Site 4
1	Patients admitted to a stroke rehab unit	C	C	C	C
2	CSBPR/QBP recommended treatments/evidence based care	C	C	C	C
3	Access to interprofessional team (Minimum of MD, RN, PT, OT, SLP, SW, RD)	C	I	C	P
4	Therapy staff: PT/OT staffed 1:6 beds, SLP 1:12 beds	P	I	P	I
5	Therapy staff – PT/OT/SLP - available at least 6 days a week	I	C	I	I
6	Team members have support and access to best practice updates/education	C	C	C	C
7	FIM completed by 72 hours	C	C	P	C
8	All allied assessments started in 48 hours of admission	C	C	C	P
9	Rehab therapy intensity – 180 min/day (at least 6 days a week)	P	P	P	I
10	Patient education including use of stroke information package	P	C	C	C
11	Goal based rehabilitation with regular interprofessional team conferences	C	P	C	C
12	Patient and Family Discharge Planning	C	C	C	C
13	Admit 7 days a week	I	C	P	I

Inpatient Rehab – Transitions – Self Assessment

	Requirement	Site 1	Site 2	Site 3	Site 4
ATR	**Acute to Rehab**				
1	Alpha FIM 60+ referred from acute are automatically accepted to rehab	P	C	C	P
2	Decision to admit to rehab made within 2 – 4 hours	I	C	P	P
3	Patient transfer arranged within 1 day of decision	C	C	C	C
4	Alpha FIM <60 – review referral for high intensity rehabilitation	C	C	C	I
RTC	**Rehab to Community**				
1	Referral for pre-d/c OT	P	P	C	C
2	Referral for Community Rehab Planning Meeting 7 days before discharge	C	P	P	C
3	Referral for CSRP 48 hours before discharge	C	C	C	C
4	Request face to face assessment from home and community care	C	C	C	C
5	Outpatient – refer and confirm outpatient appt (72 hrs post discharge)	P	C	NA/I	P
6	Link patients to community supports (stroke support groups, transportation, meals, etc)	I	P	C	P
7	Written discharge instructions provided	P	C	C	C
8	Information is transferred to Primary Care	C	P	C	P
9	Follow up check in 24-48 hours post discharge (ie follow up phone call)	I	C	I	C
RLTC	**Rehab to LTC**				
1	Refer to CSRP for transition to LTC (refer to at minimum OT)	NA/I	C	C	C

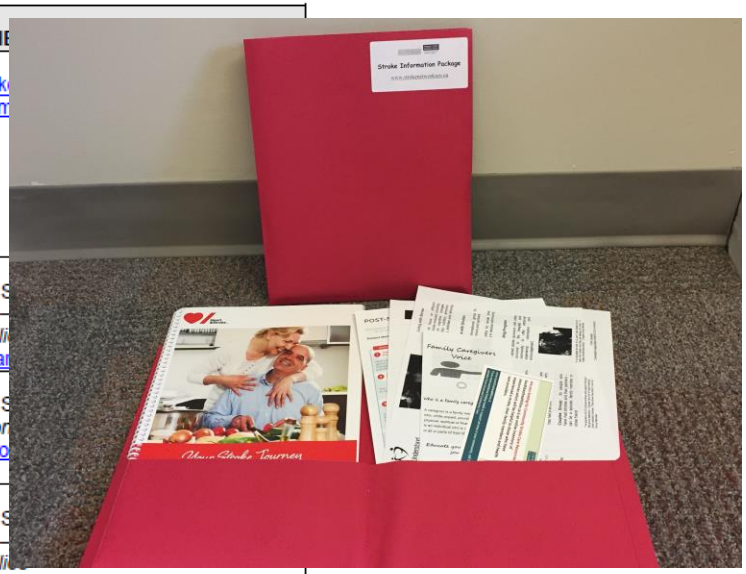
Transition Tools/Supports

STROKE NETWORK *of* Southeastern Ontario

INFORMATION ON STROKE FOR PATIENTS & FAMILIES

RESOURCE	DESCRIPTION	WHE
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.heartandstrok under Health Inform
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 S *Patient Education –* *Patients and Famili* Healthline Bookmar
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 S *Community Suppor* Stroke Support Gro
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 S *Patient Education –* *Patients and Famili* 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 Southea *Community Supports* Stroke Specific Exercise P
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 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.



Stroke Information for Patients and Families

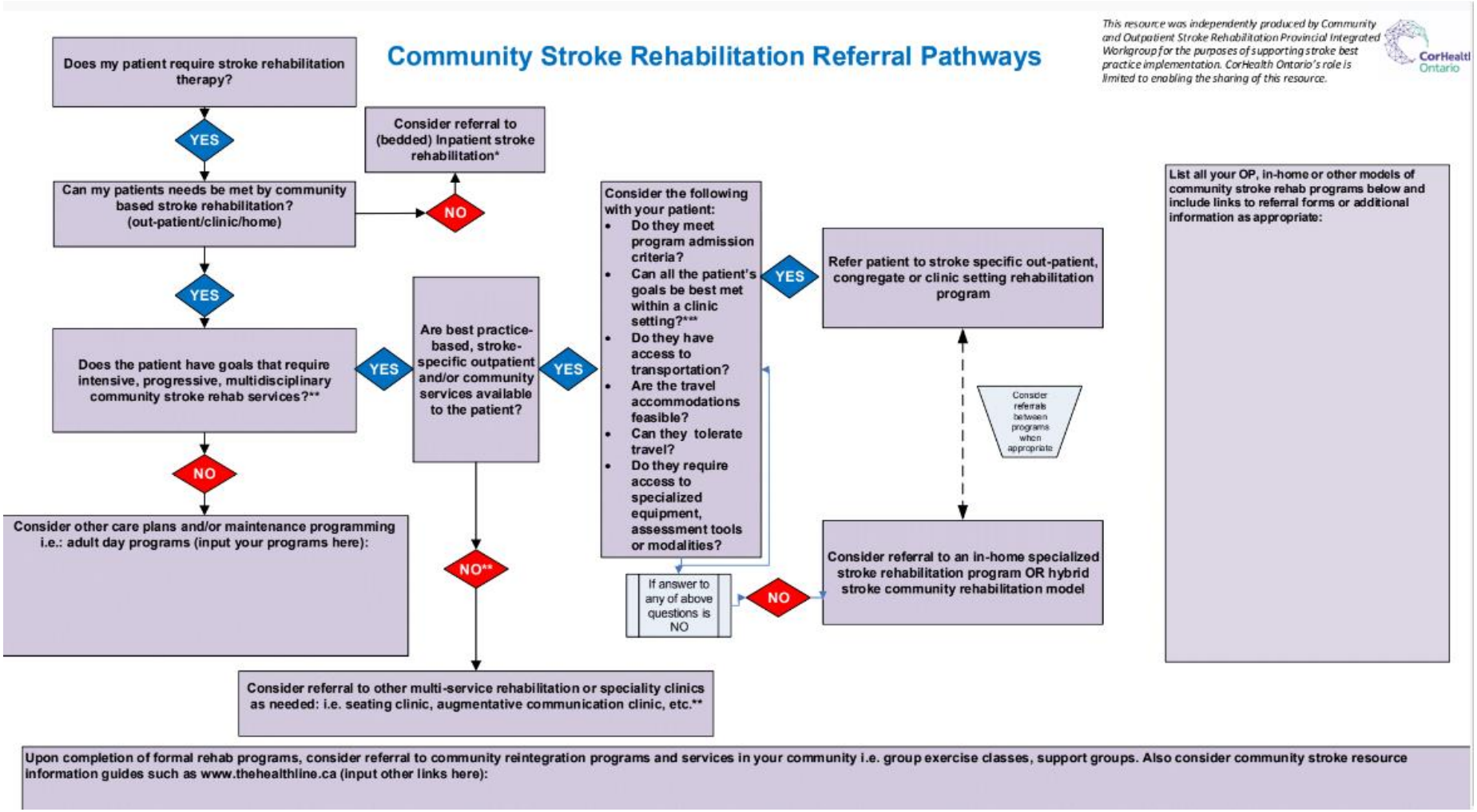
Community Stroke Rehabilitation (Outpatient) - Self - Assessment

	Requirement	Site 1	Site 2
HOutpt	**For referrals from Acute and Rehab:**		
1	Availability of PT, OT, SLP, SW with stroke expertise	**I**	**P**
2	Capacity to deliver stroke rehabilitation for 12 weeks	**C**	**C**
3	Capacity to deliver 2 – 3 visits per discipline/week	**P**	**P**
4	Process in place to ensure Social Work is offered	**I**	**I**
5	Ability for team to case conference (ideally with patient/family)	**P**	**C**
6	Assistants deliver up to 30% of therapy visits	**P**	**I**
7	Transition includes referrals to stroke specific and other community services	**C**	**P**
RTOutpt	**For Rehab Referrals:**		
1	Capacity to provide first therapy visit within 72 hours	**P**	**I**
ATOutpt	**For Acute Referrals:**		
1	Capacity to provide first therapy visit within 48 hours	**P**	**I**
ESD	**For Early Supported Discharge/High Intensity Community Rehab:**		
1	Capacity to delivery OT,PT, SLP 5 days a week for at least 2 weeks	**I**	**I**
2	Other requirements as above	**I**	**I**

Community Stroke Rehabilitation – (Outpatient)
Transition to Community Supports – Self - Assessment

Outpt to Comm	Requirement	Site 1	Site 2
1	Referral to community supports – stroke specific (support groups/exercise groups) and generic (meals, transportation, respite, home help etc.)	C	C
2	Referral to SW has been discussed and referral considered if not yet linked	P	I (?)
3	Provides written instructions for ongoing maintenance activities to continue recovery	C	C
4	Confirms patients has Stroke Information Package and able to provide if needed	C	C
5	Return to life roles and recreation is discussed and linkages made as required.	C	C
6	Consider patient goals and determine if referral to home care rehab or other services as required.	C	C
7	Discharge information and recommendations are shared with primary care	C	C

Transition Tools/Supports



HCC – Care Coordination - Self - Assessment

	Requirement	
	In-Home Services – after patient has been discharged from hospital (file stays with Access Team until services secured and pt discharge (day of discharge)	
RRN	**RRN Program**	
1	• RRN contacts patient within 24 hours to arrange a HV (including weekends)	**C**
2	• RRN visit occurs within 24-48 hours post discharge	**P**
3	• RRN report sent to Community Care Coordinator and primary care	**C**
4	• RRN will do a follow-up HV if warranted (such as if pt. confused, if pt. has++ meds and requires additional health teaching)	**C**
CC	**Transition Home – In Home Care Coordination (Community Team)**	
1	• Completes home visit and interRAI-HC – within 2 weeks (or earlier based on caseload alignment)	**C**
2	• Adjusts services and equipment/supplies based on assessment	**C**
3	• Reviews service provider reports and respond to change in pt. needs for services, equipment or supplies; monitor progress towards pt goals	**C**
4	• Service Plan Summary updates shared with Primary Care	**P**

HCC Care Coordination - Transitions – Self Assessment

	Requirement	
	Transition after Community Rehab Complete (final service provider report received).	
CCC	**Community Care Coordinator:**	
1	• Calls patient/family to confirm discharge of therapy plan	C
2	• Reviews other services and need to stay on home care program	C
3	• Offers SW again prior to discharge if not yet received	P
4	• Reviews need for and links patients to relevant community supports as able/available (e.g., stroke support groups, transportation, meals, etc.)	C
5	• Communicates summary of home care services provided and therapy discharge notification to primary care	P

Transition Tools/Supports

SOUTH EAST LHIN HOME & COMMUNITY CARE

COMMUNITY STROKE REHAB PROGRAM 2018/19

447 referrals to the Community Stroke Rehab Program. An increase of 19% from previous fiscal.

53% were referred from an **acute** care setting, **40%** were referred from a **rehab** setting and 7% were referred from other settings.

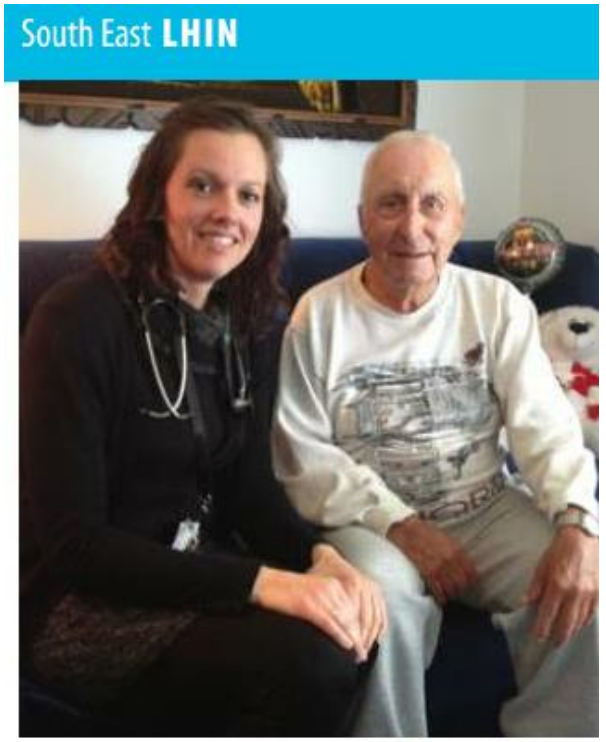
Median time to first therapy visit stable at 4 days

+1

Patients in rural and small population centres averaged one additional wait day for services.

Median age for male patients was 71 and for females was 77.

Average number of therapy visits received by patients was **15**



Rapid
Response
Nurses (RRN)

Community Stroke Rehabilitation (In-Home) - Self - Assessment

	Requirement	Team 1	Team 2	Team 3
H to CSRP	**For referrals from Acute and Rehab:**			
1	Availability of PT, OT, SLP, SW with stroke expertise	**P**	**C**	**P**
2	Capacity to deliver stroke rehabilitation for 12 weeks	**C**	**C**	**P**
3	Capacity to deliver 2 – 3 visits per discipline/week	**C**	**C**	**P**
4	Ensure Social Work is offered		**C**	**P**
5	Ability for team to case conference (ideally with patient/family)	**I**	**P**	**C**
6	Assistants available to deliver up to 30% of therapy visits	**I**	**I**	**I**
R to CSRP	**For Referrals from Rehab:**			
1	Participate in CoRP meeting with hospital	**C**	**C**	**C**
2	Capacity to provide first therapy visit within 72 hours	**P**	**P**	**P**
A to CSRP	**For Referrals from Acute:**			
1	Capacity to provide first therapy visit within 48 hours	**I**	**P**	**P**
ESD	**For Early Supported Discharge/High Intensity Community Rehab:**			
1	Capacity to delivery OT,PT, SLP 5 days a week for at least 2 weeks	**I**	**I**	**I**

Community Stroke Rehab - Transition to Community Supports - Assessment

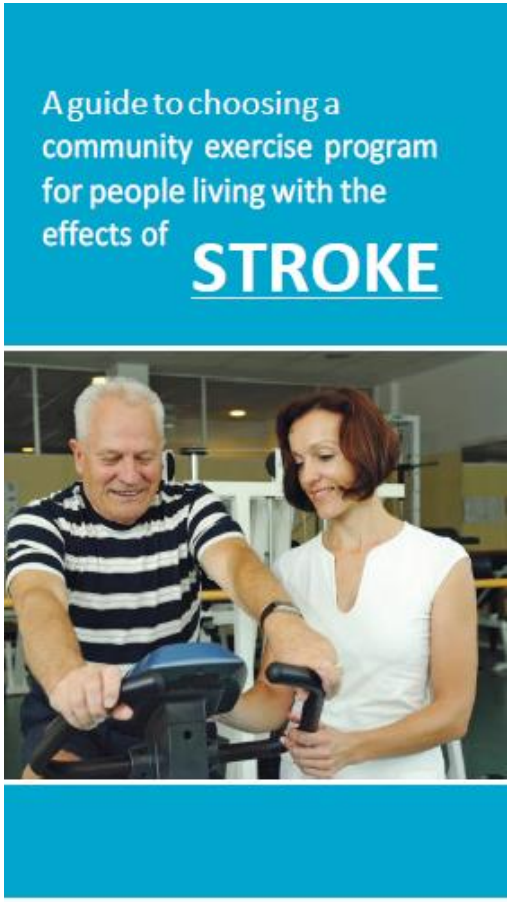
	Requirement	C	P	I
H to CSRP	**Transition from Hospital**	**Team 1**	**Team 2**	**Team 3**
	Accept referrals within 1 hour through Health Partner Gateway with LHIN	C	C	C
	Contact client to arrange visit (within 2 days)	C	C	C
CSRP to Comm	**Transition after Comm Rehab Complete**			
	Referral to community 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

Transition Tools

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 613-267-1500 X 2127 Belleville 613-969-7400 X 2633 • Outpatient Physiotherapy Kingston – Providence Care Hospital 613-544-4900 ext. 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 1-800-301-0076 X 3414 • 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 3853 • Community Brain Injury Services 613-547-6969 • Pathways 613-962-2541 • March of Dimes 613-549-4141	www.strokenetworkseo.ca Community Brain Injury Services Pathways March of Dimes



STROKE NETWORK *of* Southeastern Ontario

www.strokenetworkseo.ca

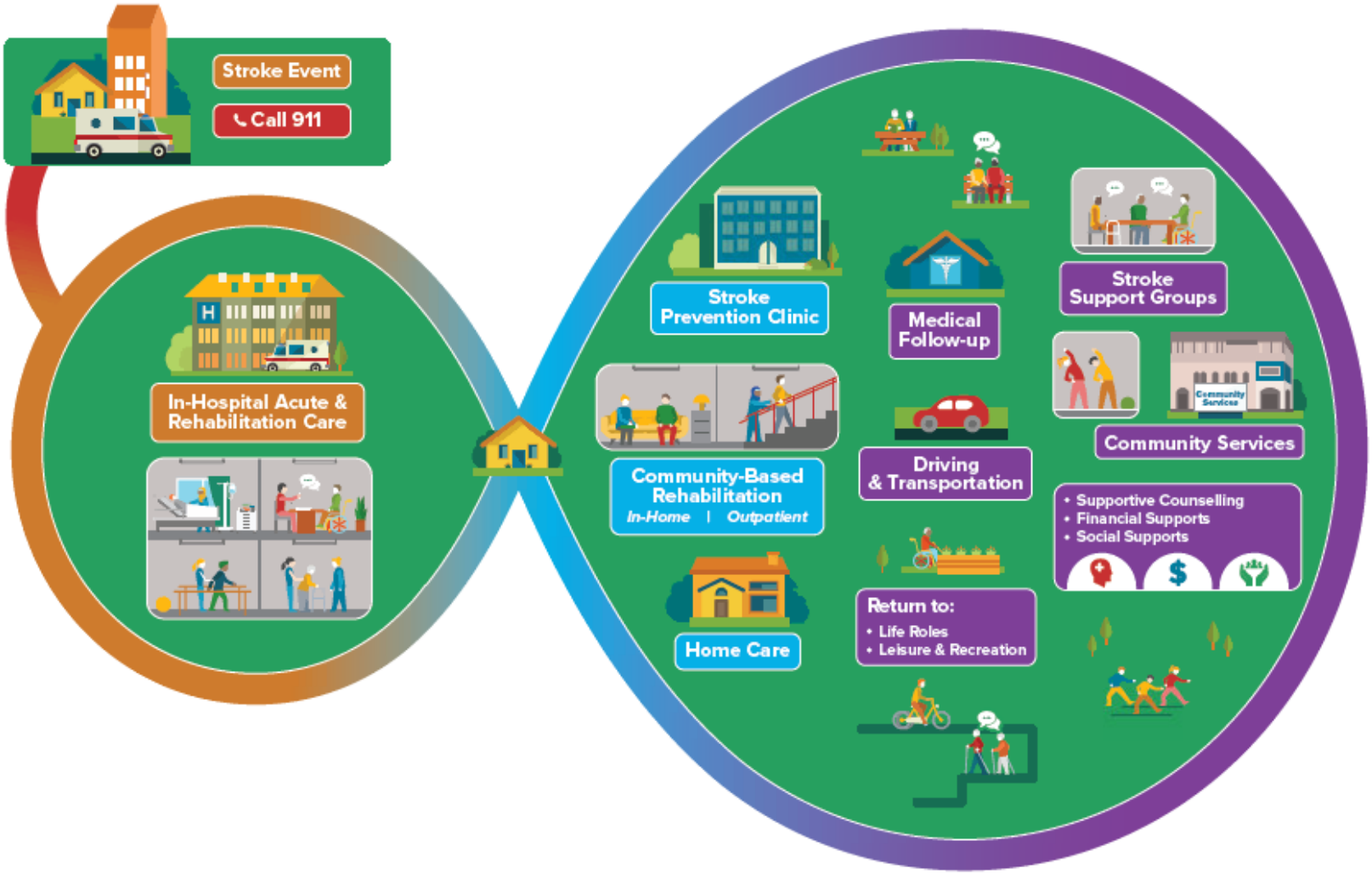
Community Support Services - Transitions – Self Assessment

CSS	Requirement	Agency 1	Agency 2	Agency 3
1	Upon receiving referral – time to first client contact is 48 hours or less	C	C	C
2	Time to in-home assessment (inter RAI CHA) for services is 7 days or less	C	C	C
3	Upon stroke referral a linkage is made with stroke facilitator within 72 hours	C	C	C
4	Process in place to connect/refer to other “sister agencies” or supports	C	C	C
5	Link between stroke specific services and “regular” services	C	C	C
6	Clients can receive some services prior to in home assessment	C	C	C

CSS Services offered	Agency 1		Agency 2		Agency 3	
	Y/N	Fee	Y/N	Fee	Y/N	Fee
Stroke Specific Services						
Stroke Support Groups for clients	Y	N	Y	N	Y	N
Stroke Support Groups for caregivers	Y	N	Y	N	Y	N
Stroke Support groups for "younger" stroke clients	Y	N	Y	N	Y	N
Stroke Social/Recreation or Peer led group	Y	N	Y	N	N	n/a
Support stroke Peer visiting in local hospital	Y	N	N	n/a	Y	N
Support stroke peer visiting in home	Y	N	Y	N	N	n/a
Stroke education – Living with Stroke Program	Y	N	Y	N	Y	N
Aphasia Conversation Groups	Y	N	Y	N	Y	N
Stroke Exercise Groups (indicate cities/town or locations in comments)	Y	N	N	N	Y	N
Other Stroke Specific Supports (please name)	Y	N	Y	N	Y	N
General Community Supports						
Meals on wheels (hot)	Y	Y	Y	Y	Y	Y
Frozen Meals	Y	Y	Y	Y	Y	Y
Home Help	Y	Y	Y	Y	Y	Y
Transportation	Y	Y	Y	Y	Y	Y
Caregiver Support and Education	Y	N	N		Y	N
Foot care (clinic)	Y	Y	Y	Y	Y	Y
Foot care (in-home)	Y	Y	Y	Y	N	n/a
In-Home Respite	Y	Y	Y	Y	Y	Y
Overnight respite	Y	Y	N		Y	Y
Adult Day Programs	Y	Y	N		Y	Y
SMART Program (Seniors Maintaining Active Roles Together)	Y	N	N		N	n/a
Friendly Visiting	N	N	Y	N	N	n/a
Telephone Reassurance and safety Checks	N	N	Y	N	N	n/a
Client Intervention and Assessment	Y	N	Y	N	Y	N
Therapeutic Recreation Programming	N	N	Y	Y	Y	N
Driver Refresher	N	N	Y	Y	N	n/a
Social or Congregate Dining/Diner's Club	Y	Y	Y	Y	Y	Y
Senior Exercise and Fall Prevention	Y	N	N	n/a	Y	N
Lifeline	Y	N	N	n/a	Y	Y

YOUR RECOVERY JOURNEY **AFTER STROKE**

STROKE NETWORK *of* Southeastern Ontario



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 hyperacute functions 5 days/week
- 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

Next Steps

- Learn from our stroke survivors
- Learn from each other
- Develop transition tool kit/navigation support in one place
- Develop a communication guide for providers to explain system elements to patients
- Review key gaps and identify opportunities – today we focus between hospital and home