Transitions across the Stroke Care Continuum

BRAG AND STEAL!

SEPTEMBER 2019

KHSC to Brockville General Hospital

- Transition issue the initiative is addressing:
  - Acute Repatriation of stroke patients to home hospital
- What is being done?
  - Following the SELHIN Repatriation Policy guidelines (48 hours)
  - Daily Bed Management meeting at 0815
  - Relationship with our counterparts eg KHSC Patient Flow – we email daily or multiple times daily to help smooth out wrinkles, challenges
- How is it going? Sustainability Plan?
  - Timely repatriation supported by senior leadership (prioritized over surgeries)
  - Recent education to our Supervisors on call
  - Ongoing education to physicians
- For further information contact:

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Kingston Health Sciences Centre to Providence Care Hospital

- Transition issue the initiative is addressing:
  - Timeliness of acceptance to Rehab program
- What is being done?
  - Fast Track for uncomplicated stroke patients with Alpha FIM score ≥60
  - Clear criteria
  - KHSC to flag referral and send additional info
  - PCH to review and make decision without on-site assessment, target 4-8 business hours to response
- How is it going? Sustainability Plan?
  - Pilot to start September 23 (10 patients)
  - Data collection for monitoring, inform need for process change
  - Regular team huddles, ++ communication between teams
- For further information contact:

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Brockville General Hospital to Community

- Transition issue the initiative is addressing:
  - Ensuring that all patients discharged from acute stroke unit receive a referral for Rapid Response Nurse and Peer Stroke Support Group
- What is being done?
  - Pink flag for patient cardex (RRN) with list of documents to include
  - Reframed discussion about peer support to offer patients and families time to consider (initial response is often to decline)
- How is it going? Sustainability Plan?
  - Going well, patients and staff receptive
  - Plan to monitor for gaps, provide ongoing education to team, manual 'catch' of patients discharged on weekend
- For further information contact:

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Quinte Healthcare Inpatient rehab to Outpatient therapy

- Transition issue the initiative is addressing:
  - Improved patient understanding of what to expect when transitioning between Integrated Stroke Unit and Rehab Day Hospital
- What is being done?
  - Take patients on tour of Rehab Day hospital space to familiarize them; get their first appointment set up before they go home
  - Connection between therapists about therapy plan if needed
  - New Rehab Day Hospital brochure
- How is it going? Sustainability Plan?
  - Going well; fortunate that OT's in both ISU and RDH have similar roles and are able to connect easily
  - Currently no waitlist for RDH so no gap in service for patient, receptionist able to give appointment card in person and OT able to review it with patient before discharge from ISU
- For further information contact:

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Community Therapy to Community Support Services

- Transition issue the initiative is addressing:
  - Community Re-Integration post in-home rehab
- What is being done?
  - Begin thinking about the long term community support plan for client early in the community rehab process; collaborate with community OT
  - Use of Transition Checklist; attend community exercise program with client if able; meet with community agencies in clients home to review Home Exercise program
- How is it going? Sustainability Plan?
  - Embedded into routine practice; done with every client
  - For concept of using home visit to make community connection for patient seamless, spread via shared work day or field work opportunities with other therapists
- For further information contact:

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