The COVID-19 Pandemic and Stroke Care

Learning and Innovation

Looking through the Rear-view Mirror

as we Plan Ahead

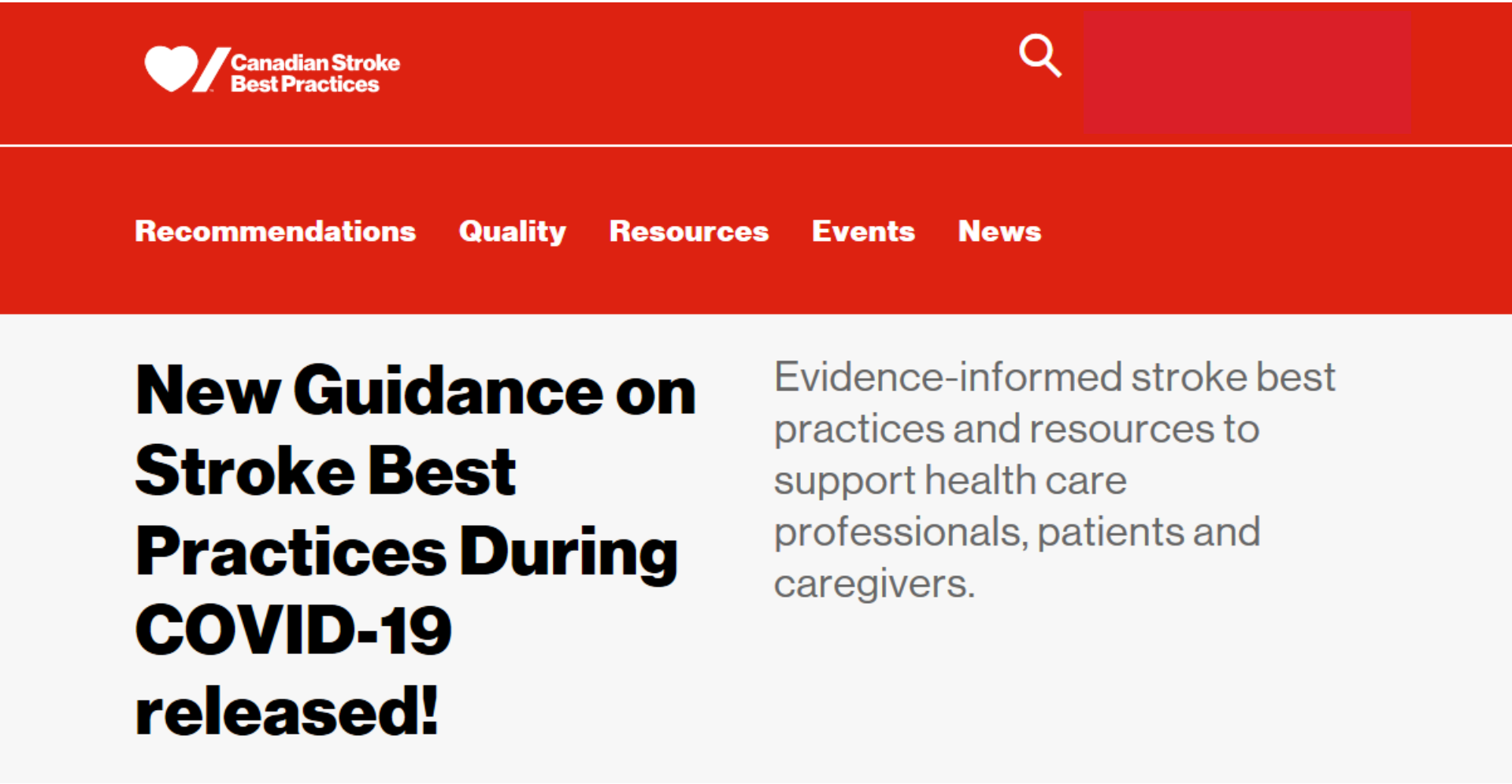
For RSSC

June 2020

STROKE NETWORK
of Southeastern Ontario

Stroke Care During COVID-19

https://www.strokebestpractices.ca/



Stroke Care Resources during COVID-19 Pandemic www.strokenetworkseo.ca

Questions asked of providers

Looking through the Rear-view Mirror as we Plan Ahead

- Your favorite three innovations/strategies in relation to COVID learning

- One learning/concern/risk to inform future planning

Prevention

- **Innovations and Strategies**
  - Virtual Platforms for high risk TIA clinics
    - many not wish to attend in person
    - QHC: ZOOM – reduced travel and parking costs
    - KHSC: use of REACTS and OTN - expanded
    - BGH and Perth – phone visits
  - Ongoing use of video for follow up visits
    - From home and inpatient rehab (PCH)
  - Contingencies for staffing coverage
  - Public awareness - Dr Jalini created a video

- **Risk/future learning**
  - Stress on those with non-COVID health conditions
    - Public perceptions and fear - ↓referrals to SPCs
    - Reluctance to attend hospital for OP testing
    - Added load for testing in ED
    - Need for ↑public messaging
  - Staff redeployment influences resources
    - e.g. QHC SPC nurse doing ↑clerical work
  - Virtual platforms less effective for NEW patients
    - Challenges with neuro exam; comorbidities
    - How to decide on in-person versus virtual?
  - Need to evaluate quality of virtual care

Got to know patients and families in their homes-see them as a person instead of seeing them as a patient

Primary Care Physician in a webinar

We continue to "see" urgent cases in a timely manner. The team is eager to transition back, with a safe plan, to in-person consultations for new patients. There are limitations with new consults and the technology especially in the setting of comorbidities such as dementia.

Michelle Slapkauskas,
Stroke Prevention Clinic Nurse, QHC

NEED FOR Public Awareness during COVID-19

Stroke is a medical emergency. Do not hesitate.
Call 9-1-1 even during the COVID-19 pandemic.

Learn the signs of stroke

F ace is it drooping?

A rms can you raise both?

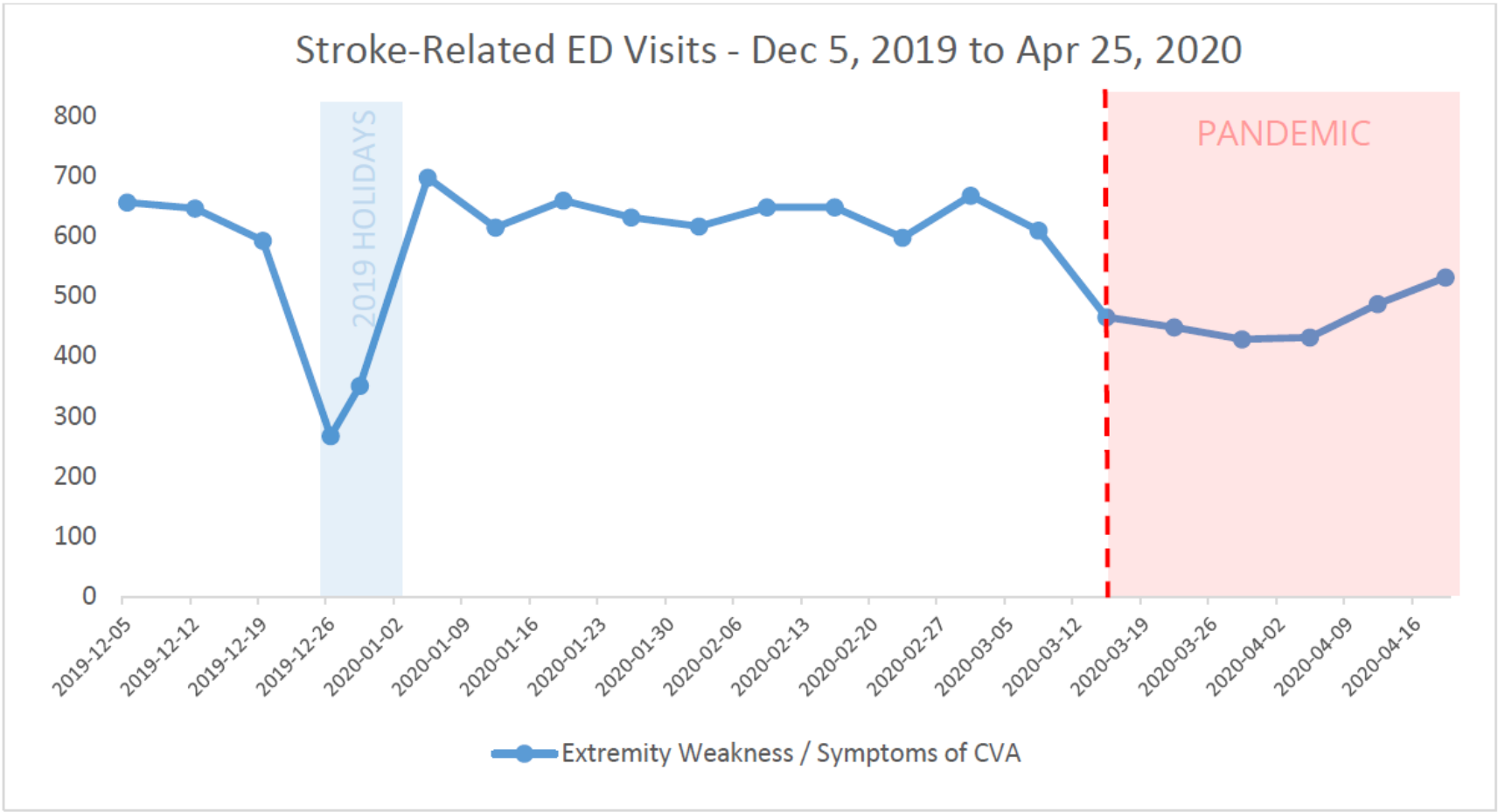
S peech is it slurred or jumbled?

T ime to call 9-1-1 right away.

heartandstroke.ca/FAST

Heart&Stroke™

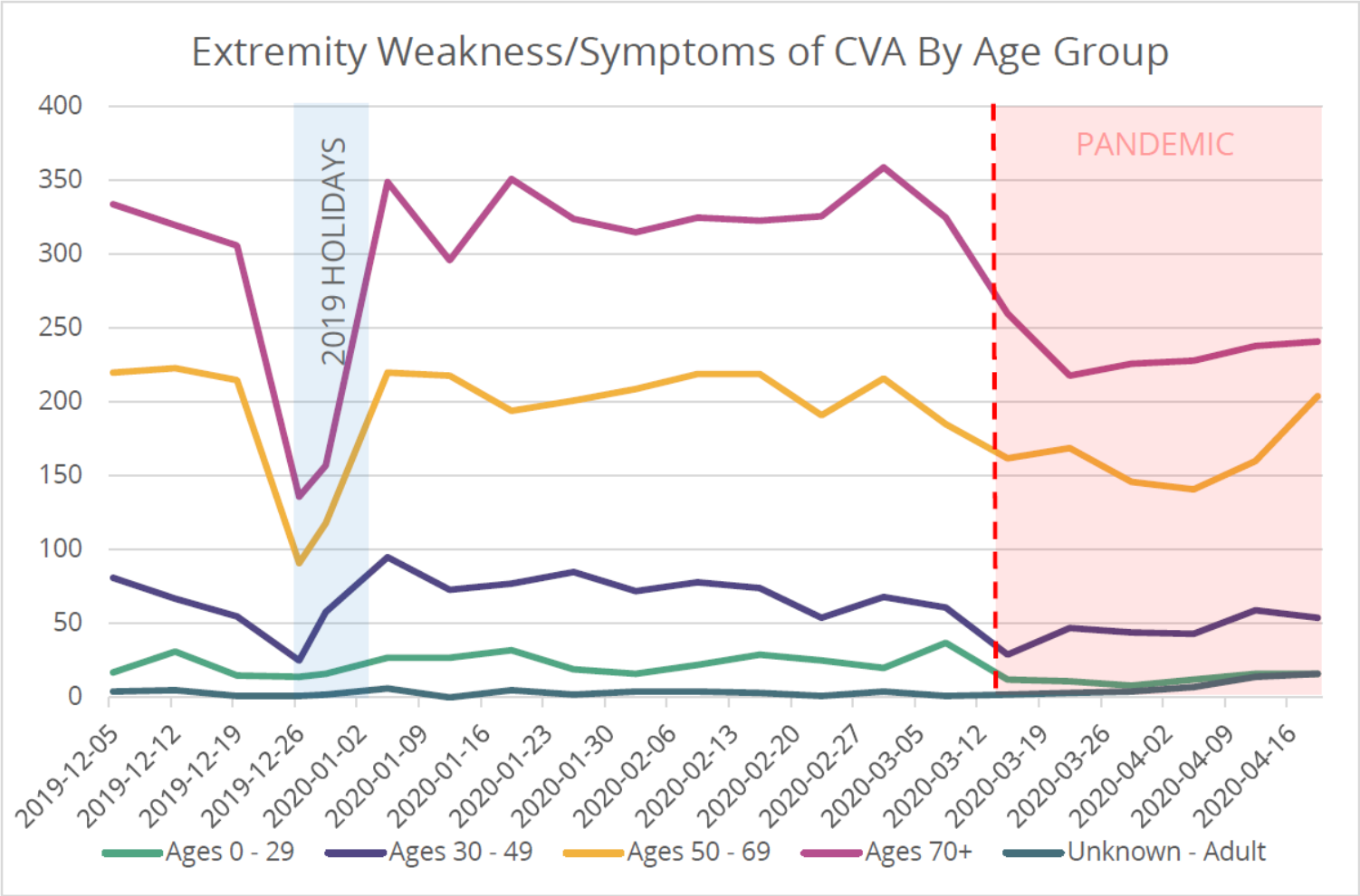
Ontario eCTAS data: Decrease in Stroke - related ED Visits during COVID-19



Data Source: *Ontario Health Cancer Care Ontario eCTAS Stroke Analysis - April 27, 2020 using weekly date from December 5 - April 25, 2020*

April 30, 2020

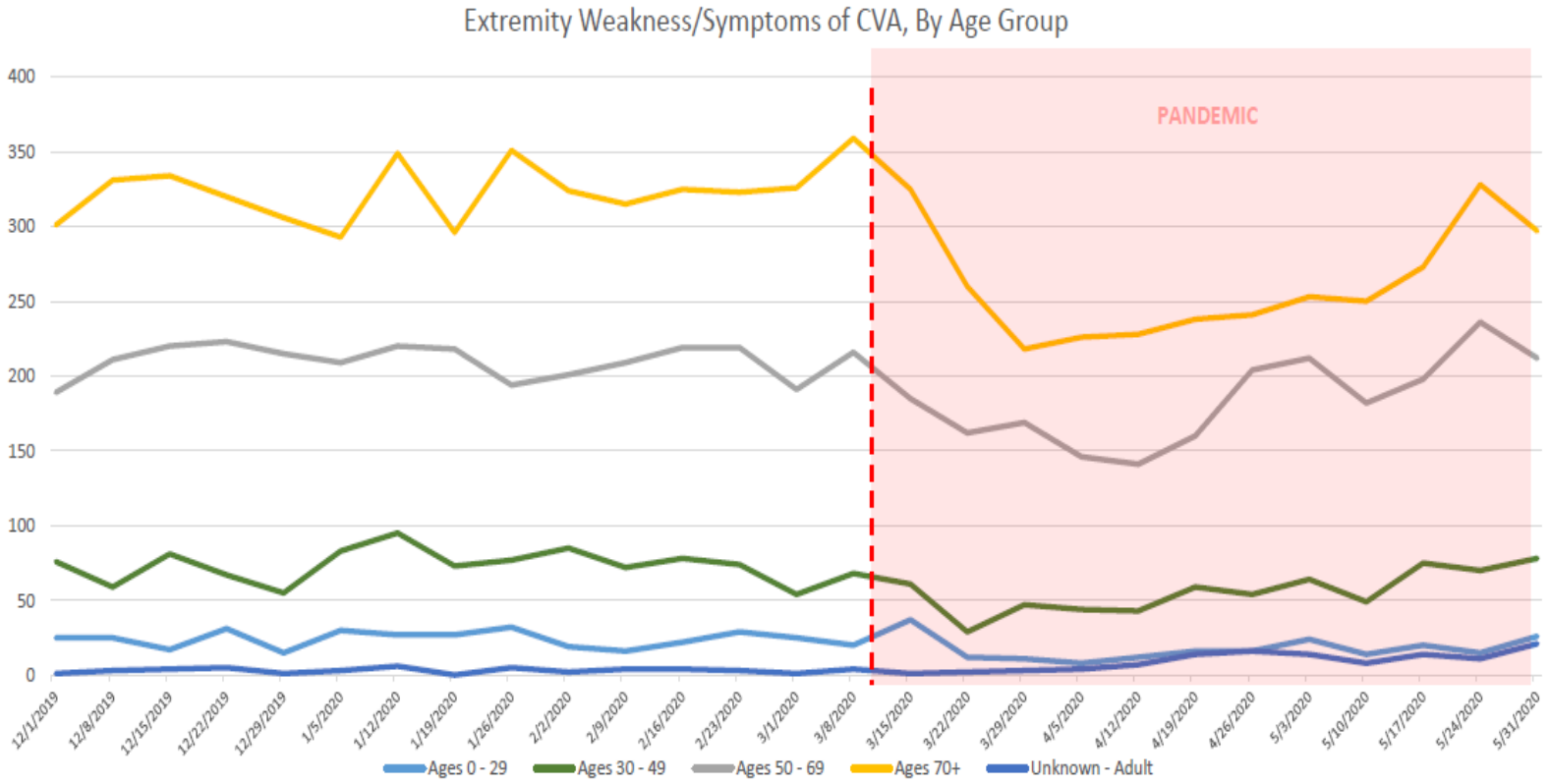
Ontario eCTAS Stroke Data by Age



Data Source: *Ontario Health Cancer Care Ontario eCTAS Stroke Analysis - April 27, 2020 using weekly date from December 5 - April 25, 2020*

Stroke Related Presentations

eCTAS data updated May 2020



Hyperacute

- **Innovations and Strategies**
  - Frequent communication - shifting info; need fast decision-making
  - "Protected" ED Stroke Protocols at KHSC & QHC- safe workflow, less people; conserve PPE; field-tested
  - "Protected" In-hospital Stroke Protocol
  - Re-screening at ED door
  - "Rapidly deployed Telestroke" as contingency for access to stroke specialists
- **Risks/Future Learning**
  - Public perceptions and fear -↓stroke/TIA volumes presenting though ↑ EVT transfers
  - Reluctance to attend for essential OP testing = greater load on ED
  - Communication across pre-hospital/ED with consultant teams (KHSC)
  - Absence of grassroots QI meetings – variation creeping back into code stroke process (QHC)
  - Need to evaluate quality of local telemedicine

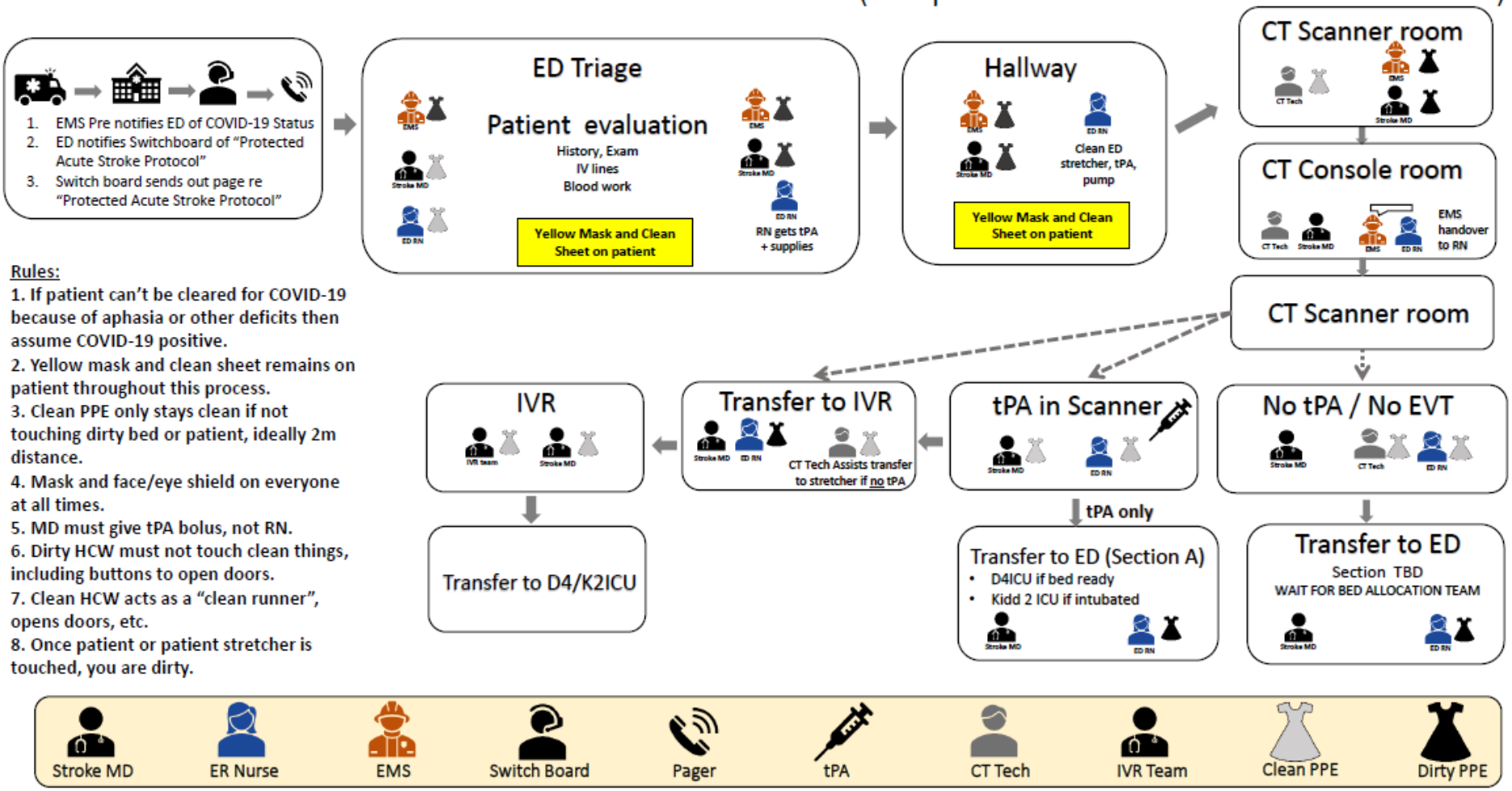
I was nervous about this & needed to practice the "Protected" Acute Stroke Protocol –thank you for walking us through the steps.
KHSC ED Nurse

The principles that went into the Protected Stroke Protocol helped.
Stroke Neurologist

Great work and great collaboration
KHSC Infection Control Practitioner

Communication needs extra attention during COVID-19
Regional Stroke Team

Protected Acute Stroke Protocol (Suspected or Confirmed COVID-19)



Rules:

1. If patient can't be cleared for COVID-19 because of aphasia or other deficits then assume COVID-19 positive.
2. Yellow mask and clean sheet remains on patient throughout this process.
3. Clean PPE only stays clean if not touching dirty bed or patient, ideally 2m distance.
4. Mask and face/eye shield on everyone at all times.
5. MD must give tPA bolus, not RN.
6. Dirty HCW must not touch clean things, including buttons to open doors.
7. Clean HCW acts as a "clean runner", opens doors, etc.
8. Once patient or patient stretcher is touched, you are dirty.

Acute/Integrated Stroke Units

- **Innovations and Strategies**
  - Family virtual visits and teaching using tablets:
    - Face Time, "aTouchaway" , ZOOM to connect families
  - Ensuring connections with homecare prior to discharge:
    - BrGH connected with care coordinators and set up a 3x/week check-in with hospital coordinators and flow team.
    - Daily flow meetings across KHSC, PCH and Homecare
  - "Rapidly deployed Telestroke"
    - contingency plan for rounding with stroke neurologist
    - potential for mentorship region-wide
  - Critical Care contingency plans
- **Risks/Future Learning**
  - Challenges with visitor policies
    - be prepared - alternate communication strategies for family
    - tablets, organized plan, assigned staff
  - Shared spaces and lack of casual coverage – e.g. KHSC SLP
  - Communication and transitions:
    - Focused attention to changes within our own hospitals without knowing what was happening elsewhere
    - Will family still have access to virtual visits?
    - Added challenges with DC planning; links with home care
  - Sustaining ASU/ISU targets despite bed map changes
  - Impact of COVID on stroke volumes over time

Family found the virtual visits reassuring – we are making a conscious effort to ensure families are engaged and understand what is happening. Families have told us they are thankful to see their loved one and hear from the team.

Natalie Aitken, BrGH Social Worker, Patient Experience & Engagement Specialist

Through the actions we've taken, we're showing that social distancing doesn't mean social isolation.

Sarah King, Runnymede's Director of Client Relations and Community Engagement
OHA news June 3

We could keep doing some things differently!

Rapidly Deployed Telestroke

Inpatient Rehabilitation

- **Innovations and Strategies**
  - PCH-KHSC Rehab admission assessments completed offsite
    - adapted quickly; going well; consider future workload/resource
  - Family virtual visits and Family teaching
    - Especially helpful with severe stroke, communication deficits, long stays
    - understanding of stroke; feeding tubes, insulin delivery; mobility
    - inclusion in rounds
  - More frequent use of home exercises
    - paper education and information for patients to take home
    - including future progressions
  - Community rehab planning meetings with community therapists
    - continuing over phone/video
    - potential to spread to more than 1 discipline
    - some sites using ZOOM/Face Time with hand-held technology to link with community provider before DC (OT:OT); patient/ therapists can see each other
  - Pre-discharge OT home assessments occurring more quickly
    - verbal reports OT to OT for timely exchange of information
- **Risks/Future Learning**
  - Biggest challenge: loss of in-person family visits
    - Essential for engaging patient & family in rehab teaching
    - Added awareness and planning in future
  - Changes in use of therapy spaces
    - group therapy, gym access; specialized equipment; group dining
    - Quarantines when moving across sites
  - Changes in how therapists deployed
  - Virtual Rehabilitation
    - Continue linking the patient across care sectors
    - Organizational supports for delivery of virtual rehabilitation care

The OT and I connected with the patients family virtually and were able to demonstrate the person's functional status (stair performance, transfers, ambulation) and review safety.

Shannon Mosher, BrGH Physiotherapist

We have been connecting more with the family in rounds by phone – where before, if they did not attend in person, we did not connect as consistently

Natalie Aiken BrGH SW

There has been added dialogue across sites and sectors during COVID– I hope this will continue to be strengthened as it facilitates the "one team" approach and makes for added continuity of care!

Dr Ben Ritsma, Physiatrist, PCH

Rehab: Outpatient & Community

- **Innovations and Strategies**
  - "Driveway or patio visits"
    - physically distant visits that enable eyes-on with/without family members
  - ZOOM/face Time – Community Rehab Planning Meetings
  - Planning re-opening (Rehab Day, QHC):
    - Setting priorities for in-person visits
    - Scheduling and spacing out in-person time slots; altered hours?
    - Screening
    - Physical distancing & cleaning: waiting room/washroom/equipment/parking

- **Risks/Future Learning**
  - Assisting patients to understand value of rehab to recovery
    - Increase in numbers declining therapy
  - Virtual care does not replace in-person/hands-on
  - What virtual elements to sustain?
    - Readiness by both patients/therapists for future needs
  - Virtual care within programs/systems must be planned <u>with</u> the care experts
  - Significant variability in adoption of virtual care across organizations and/or individual therapists
    - Variable access to organizational support for virtual equipment/resources
    - Setting up webcams, laptops, headsets, home offices at own expense
    - Virtual therapy requires more space and set up e.g. to demonstrate
  - Need emphasis on a system approach
    - impact of one sector on another
    - all outpatient care closed and diverted to home care without adequate planning for rehab service (virtual care systems, PPE, funding)

I'm trying to be creative with other options such as 'driveway visits' when it is safe to do an outdoor session"
Homecare PT

We have been having success with increased number of OT visits in home care given we are not yet able to transition to rehab day hospital
Erin, QHC Lead OT

We need to spend more time liaising with the family and home care therapies when planning discharges
QHC Therapists

Community Supports

- **Innovations and Strategies**
  - Flexible approach to respond to individual needs and mode of connection preferences
  - Phone check-ins with survivors and caregivers to reduce isolation, offer continued support, information sharing
  - Use of ZOOM platform for support groups including use of white board for aphasia groups
  - Use of teleconferences for stroke survivor/caregiver support (e.g. “virtual bingo”)
  - Area-specific or smaller support groups based on established connections
  - Facebook pages: information sharing and ongoing connection
  - Modified information to accommodate individuals with aphasia or lower literacy
- **Risks/Future Learning**
  - Identifying those at higher risk requires an individual assessment (e.g. not necessarily the frail elderly)
  - Clients & caregivers expressing fear of losing post-stroke gains due to lack of access to therapies, stroke support & aphasia groups.
  - Pre-planning to determine each individual access to and capacity for virtual connections including privacy/consent concerns
  - Introduce and practice virtual strategies in “normal times” to avoid steep learning curve

Isolation is a big risk in the community
Jennifer Bishop, VON

We tried out the white board in ZOOM for our aphasia meetings and it worked quite well; we are all learning together!
Lynda Lennox, Support Group Facilitator, VON

Use of ZOOM for our aphasia group was very helpful.
Caregiver

The virtual Bingo was a hit; it took people’s minds off their worries and they had fun.
Lorraine Pyle, Support Group Facilitator, CCSH

We learn as we move forward to think outside the box.
Support Group Facilitators

Long-Term Care

- **Innovations and Strategies**
  - Strategies to engage and support families & residents
    - virtual visits (FaceTime, Zoom, Skype),
    - window visits,
    - social networking (Facebook, What's App, Twitter, Instagram),
    - pen pals, storytelling videos (residents & families)
  - Southeast C.A.R.E. (Coordinating Access to Resources Electronically) Network
    - group formed to share learning across the region
    - new venue to connect on best practices, innovations and challenges
  - Close connection with & supports from public health

- **Risks/Future Learning**
  - Supporting LTC Homes early in a pandemic situation.
  - Risks of social isolation – need to safely connect residents and families
  - Strategies for effective infection control when working with residents experiencing dementia
  - Recruitment and retention challenges
    - Limited staffing resource pre-pandemic
    - Many part time staff shared across Homes
    - Perfect storm for spread of infection & domino effect
    - Need for equitable pay for staff in LTC sector
    - Decreased interest in PSW programs given complexity of care challenge compared to other occupations with similar compensation.

With initial focus on acute care, LTC became the "forgotten sector".

Once COVID-19 hits vulnerable LTC populations, it's very hard to control. We needed more prevention sooner.

"I didn't know if I should place him. Finally, I did because the care [at home] was so hard. Then, in a month, he was gone and I was not even able to go in to say good-bye – it all happened so fast. I just feel guilty and sad."
Family Member

Education & Knowledge Translation

- **Innovations and Strategies**
  - Move to MS Teams over Bell dial-in
    - richer meeting/↑options
    - will change how we do our regional work
  - Successful virtual education delivery
    - Physician stroke school- March and June
  - ↑Creativity and learn from others
    - test virtual approaches
    - link beyond our region
    - re-purpose other work

- **Risks/Future Learning**
  - Stroke care requires hands-on practical skills
    - how to deliver hands-on learning in a virtual manner?
    - Smaller sessions locally?, more shared workdays?
  - Some logistical barriers
    - Many clinicians do not have access to a quiet, private space to participate in virtual sessions at work
  - Teaching skills – how to best engage learners in virtual sessions

"Webinar format is just as good as in person, except for the limitation of demonstrating the neuro exam."
BrGH Stroke School Evaluation Survey

"Virtual courses save travel, time and money."
BrGH Stroke School Evaluation Survey

It was great to participate virtually in the European Stroke Conference for free!
Neurology Resident

A few general quotes

- ***Now more than ever, we've needed to work as a system***
- *We needed to acknowledge the fear that had to be overcome*
- *Frequent daily communication helped adjust to constantly shifting information and policy –helped maintain flexibility*
- *Coordination and leadership: capable and engaged staff set the example; redirect, repurpose, remain flexible*
- *Take into account life outside of work; contingency planning for loss of personnel or work from home*
- *The hospital was very proactive in putting staff screening, protected protocols and specialized units in place; keeping all staff updated every day.*
- *" Let's make it happen" – Creative solutions - Amazing how quickly people and organizations came together to change practice in a crisis – creating new protocols, moving large volumes of patients to build capacity, spirit of "just do it" can get things done when "traditional boxes" are lifted*
- *Ability to connect using a variety of online programs; seeing people virtually in person "has been a nice surprise" after working at home in isolation*
- *MS teams brings everyone together virtually*

- ***We have experienced unprecedented challenges during the pandemic; we can quickly adapt while sustaining stroke best practices.***

THANK YOU!!

Discussion

Stroke Survivor & Family Engagement

Quality of Virtual Care/Rehabilitation/Transitions/Education

Public Perceptions