Southeastern Ontario Acute Stroke Collaborative Meeting

Kingston General Hospital Stroke Unit

Kingston General Hospital

Mobility

PT & OT Assess:

- Baseline information
- ROM, strength, coordination, sensation & mobility

Mobility status is posted on bedside white boards:

- Level of assistance
- Gait aid (if applicable)
- Any additional information/ direction

- Direct Communication with nursing staff & personal care aids.

- Mobility activities are recorded in the Clinical Flow sheet after each mobility activity

Patients are encouraged to be up in chairs for meals

Education is provided to patients & family:

- Exercises
- Safe mobility
- Gait aids & equipment use
- Follow up if required

HEALTH EDUCATION

Mobility

- ✓ Mobility status is documented in the clinical flow sheet, kardex, and at patient's bedside:
  - ✓ Frequency of activity
  - ✓ Level of assist
  - ✓ Aids used
- ✓ PT monitors flow sheet & progress notes regarding progression
- ✓ Direct communication between staff & team members to identify any patient mobility changes
- ✓ Patient feedback

- ☺ **What works well?**
- ☺ Mobility signs are posted & updated regularly in most cases
- ☺ Mobility aids are available for each patients & the correct aid is at patient's bedside

Dysphagia Screening & Management

No Food or Drink

POST STROKE

Swallowing screen completed by trained nurses – STAND order set and protocol

Negative screen: pureed texture x3 meals with monitoring then progress to regular texture

Positive Screen: SLP referral for swallowing assessment

Excluded from screen: SLP referral for swallowing assessment

★ **If patient is to remain NPO**:
- NG tubes are put in promptly for meds and feeds if consistent with patient wishes
- Dietitian consulted to assess needs

- If patient started on oral diet after SLP assessment/STAND: educate staff and team members to notify SLP/doctors if S&S of aspiration.
- SLP monitors, reassess, and upgrade patients diet texture as appropriate
- RD optimizes oral diet & decreases/stops tube feeding as appropriate

Dysphagia Screening & Management

- ✓ Number of patients receiving STAND is monitored as part of stroke accreditation
- ✓ STAND assessment forms remain part of the chart
- ✓ Dysphagia working group reviews issues that come up with STAND
- ✓ RD and SLP review diet orders as part of monitoring patients

- ☺ **What works well?**
- ☺ Swallowing screens help prevent patients who come in late Friday or on weekend from being NPO for longer than necessary and receiving unnecessary feeding tubes
- ☺ Staff are very aware of the need for swallowing screen after a stroke
- ☺ Open and frequent communication between staff & SLP. Staff contacts SLP when they witness any S&S of swallowing problems

Aphasia & Communication

SLP consulted for aphasia when:

- There is communication impairment
- Patient requires a formal communication assessment to identify communication needs for rehab/home
- Safety issues r/t discharge home
- Patient/ family would benefit from education

Pts with severe aphasia are excluded from OT, administered 5-min MOCA neurological protocol.

Follow up with modified cognitive screening sensitive to communicate difficulties. Modified cognitive screening is individualized after liaising with SLP.

Modified cognitive screening may include but not exclusive to: reading, writing, pictures, hand sequencing, and scanning tools.

SLP & OT collaborate regarding communication & cognition

Supportive conversation strategies are communicated to staff through the chart notes, kardex, and team rounds

Nursing staff updates team regarding success of strategies & notify consulting services coming to the bedside of strategies which work with patient

Aphasia & Communication

- ✓ Patient has the means to express their needs
- ✓ SLP & OT collaborate regarding communication and cognition
- ✓ Supportive conversation strategies are communicated to staff through chart notes, kardex, and team rounds
- ✓ Nursing update team regarding success of strategies and notify consulting services coming to the bedside of strategies that may work with patient

- ☺ **What works well?**
- ☺ SLP & OT work together to assess and address communication needs
- ☺ They communicate and post strategies for the team and patient families

Transitions

- On admission, an initial assessment planning for transition and discharge is started by all team members (ie functional status)

- If acute medical needs can be managed from their home hospitals, patients are repatriated when a bed becomes available
- Paperwork – case manager, charge nurse are liaising with admitting and the potential accepting acute care hospital

- Allied Health complete parts of rehab forms
- Notes or discharge summaries from allied health are sent
- Stroke team members communicate with their respective professions at receiving hospitals as required
- Transfer delays are brought to attention of patient flow coordinator or program director as appropriate

Transitions

- ✓ Team communicates regarding upcoming discharges
  - ✓ Informally – daily on stroke unit (nurses, doctors, allied health stroke team)
  - ✓ Formally – at white board daily (charge nurse, stroke case manager, and social worker), weekly stroke team rounds, weekly discharge planning rounds
- ✓ Length of stay and concurrent reviews of stroke service represent two ways transitions are monitored

- ☺ **What works well?**
- ☺ Stroke specialist case manager acts as lead and communicates to team members to ensure they have done their parts
- ☺ Patient flow coordinator is available to assist with long delays

Strengths

- ✓ Interprofessional collaboration
- ✓ Team communication
- ✓ Regular team meetings
- ✓ Stroke unit: better care when patients and team are together in one geographical location

Challenges

- ☹ Limited allied health staffing (no weekend coverage)
- ☹ Increased volume of patients
- ☹ Patients located in multiple units (ER, ATU, Stroke Unit, other floors)

Areas For Improvement

- **Mobility**
  - Inconsistency in the use of the clinical flow sheet to document mobility
- **Dysphagia Screening & Management**
  - Patients are occasionally fed post stroke without swallowing screen or assessment
  - Patients are either not made NPO or areas of the hospital may not be familiar with protocol and allow patients to eat
- **Aphasia & Communication**
  - Improve patients and family satisfaction if more tools and strategies were available for staff and patients so patients are better able to express needs and staff are better able to assess needs.
- **Transitions**
  - Consistent messaging and managing patient and family expectations regarding stroke care when transitioning from ICU to Stroke unit
  - Unclear what is available at local hospitals which can result in patients staying at KGH
  - What allied health is available? Is rehab available in that area? What procedures/tests can be done?
  - Lengthy wait times for patients being transferred back to their ‘home’ acute care setting

THANK YOU!