STROKE NETWORK of Southeastern Ontario

Project Summary – April 2019
Rapid Response Nurse Pilot - Community Stroke Rehab Populations (KHSC, QHC and BrGH)

Summary of Pilot: To further support transitions from acute stroke units and respond to patient and provider feedback, a pilot of referrals to the South East LHIN's Rapid Response Nurse (RRN) program, in conjunction with referrals being made to the Community Stroke Rehabilitation Program of the South East Local Health Integration Network (LHIN), occurred between October 2017 and March 2019. Three consecutive implementation phases/pilots occurred based on positive results from initial pilot site. A small project team was brought together with representation from the South East LHIN, Stroke Network of Southeastern Ontario (SNSEO) and each participating hospital (Kingston Health Sciences Centre (KHSC), Quinte Health Care (QHC) and Brockville General Hospital (BrGH) during their respective pilots. Prior to initiating referrals, a review of the RRN program with key hospital team members occurred at each site as well as a review of referral processes and required documentation. Rapid Response Nurses were provided key stroke-related education materials and were linked to additional resources and/or training as required (e.g., two RRNs attended an aphasia workshop provided by SNSEO). Key process metrics were tracked and project teams met regularly to review findings and address process issues during implementation.

Pilot Results:

- KHSC – 27 patients referred between October 2017 and July 2018
- QHC – 29 patients referred between February and July 2018
- BGH – 16 patients referred between November 2018 and March 2019

As patient populations were quite similar, results have incorporated findings from all sites.

- Total referrals 72
- 60% of patients (n=43) received an RRN visit
- 30% of patients (n=22) were not seen (includes patient declining service, patient residing out of SE region, LTC resident and not authorized at SE access point)
- 10% of patients (n=7) did not have sufficient accurate information available for audit

RRN interventions

Medication Reconciliation:

- Resolution of medication discrepancies including following up on missing prescriptions, wrong dosages, missing medications in blister packs from pharmacies
- Reinforcing medication purpose as needed
- Following up with pharmacy and prescriber regarding medication and dosage questions
- Teaching correct inhaler technique
- Connecting with pharmacy to arrange blister packs
- Directions to patients regarding old/unused medications
- Completing medication reconciliation summary which is left in the home for the patient and shared with the primary care provider

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Teaching

- Reinforcing the teaching that occurred in hospital (e.g., review of "My Stoke Journey" book).
- Providing information re smoking cessation and local resources
- Formulating safety plans related to mobility and the home environment (e.g., scatter mats and fall risk)
- Liaison with other care team members such as: Care Coordinator, Service Providers

Primary Care Provider (PCP)

- Completion of 6-page clinical assessment which is printed and left in the home for the patient, and sent to the primary care provider.
- Assisting patients to make follow-up PCP appointments and confirm other appointments (e.g.,~~i.e.~~ lab work, neurologist, sleep study clinic, pacemaker clinic).

Family Support

- Reinforcing teaching with family as the stoke event impacts on the entire family and support system.
- Answering questions for patient and family, as well as discussing community resources (e.g., the SMILE program, meal preparation services, and the care coordination role of the SE LHIN)
- Facilitating referrals to social work as needed (e.g., challenging family dynamics)

Analysis/Recommendations:

As the project team reviewed the results, the many benefits of the RRN service were very clear. All encounters received intervention(s) from the RRN. This aligns with expected results for this pilot. When a stroke occurs, it is always an unplanned and typically a life-changing event for the patient and family. As well, for this subgroup being referred to Community Stroke Rehabilitation Program, there is usually a new disability. It is an overwhelming time for patients and families and each transition point is a challenge. Of note, the KHSC and QHC combined analysis showed 40% of patients in the stroke cohort were identified with a medication discrepancy compared to 26% of patients within the total RNN referral group. No medication discrepancy identified in Brockville however medication management and teaching was still applicable. RRN visits have been implemented across the region to support potentially challenging transitions in the first 24 – 48 hours after Acute Stroke Unit discharge. RRN interventions improved safety and medication management and provided support for patient and family related to new stroke diagnosis. A key success factor is hospital teams supporting the referral process with accurate and timely discharge summaries and medication lists. Based on the results, it is the recommendation of the project team and supported by the South East LHIN that ALL patients being referred from an acute stroke unit to the Community Stroke Rehabilitation Program in the SE region be referred to the Rapid Response Nurse Program.

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