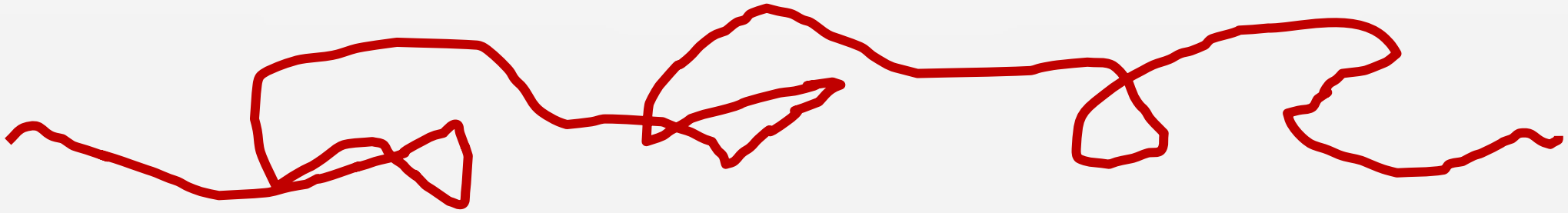
STROKE NETWORK *of* Southeastern Ontario

Managing Transitions of Care Best Practices

Acute Stroke Care Collaborative 2017

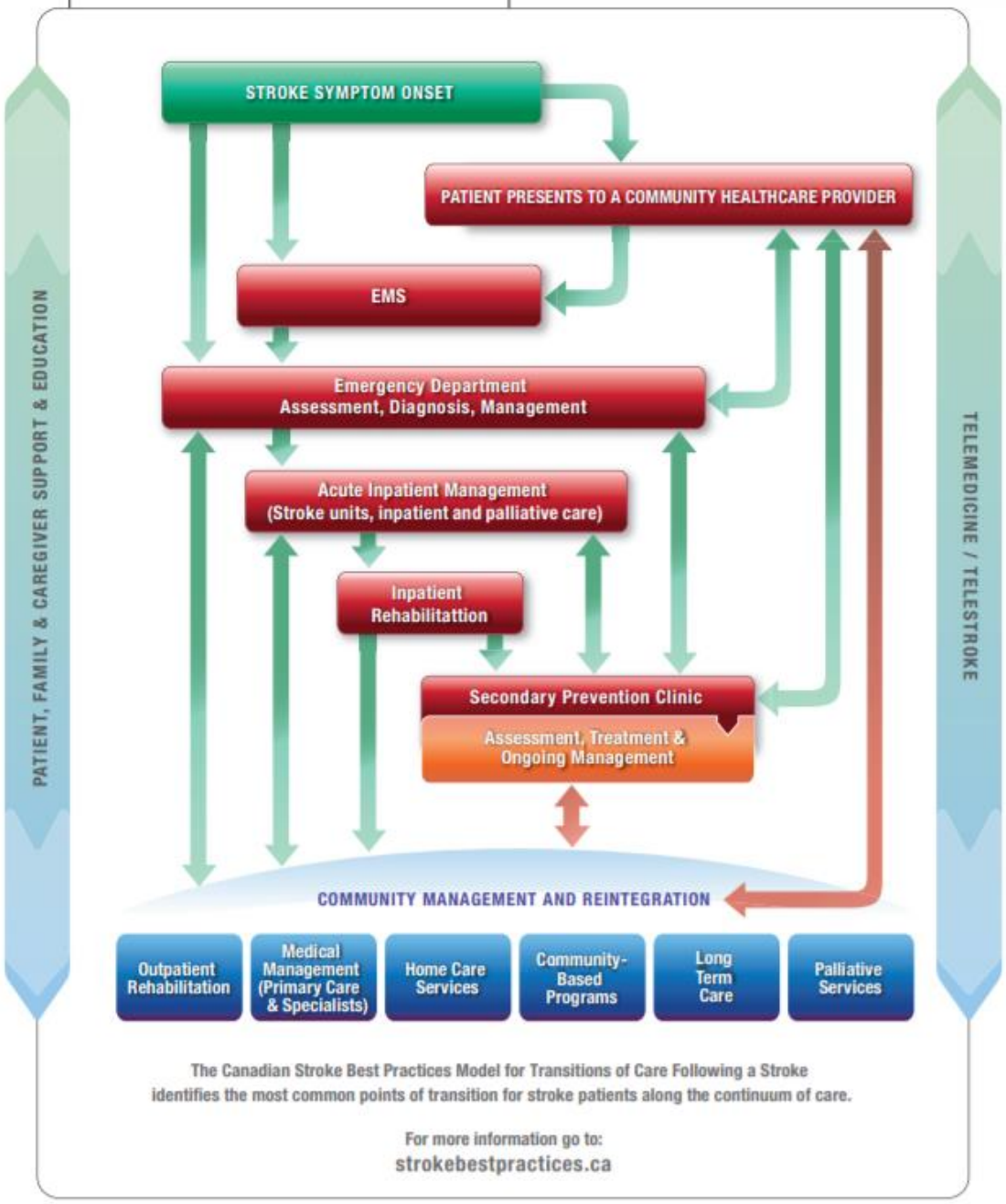
Transitions Defined

Movement of patients among: providers, different goals of care, and across the various settings where healthcare services are received (CSBPR, 2016)



The Canadian Stroke Best Practices Model for TRANSITIONS OF CARE FOLLOWING A STROKE

Canadian Stroke Best Practices



The Canadian Stroke Best Practices Model for Transitions of Care Following a Stroke identifies the most common points of transition for stroke patients along the continuum of care.

For more information go to:
strokebestpractices.ca

Introduce Regional Stroke Dashboard

Sample "transition" data from 2016/17

Stroke Unit Utilization
(Target is 80% of Patients to Spend Time in a Stroke Unit):

QHC: 89%	KGH: 78.8%	BrGH (LLG Stroke Unit): 87.8%

Median Time to IP Rehab from Stroke Symptom Onset
(Target is 5-7 days)

QHC: 6.0 days	PCH: 14.0 days	BrGH: 11.5 days	PSFDH: 10 days

Canadian Stroke Best Practices: Transitions

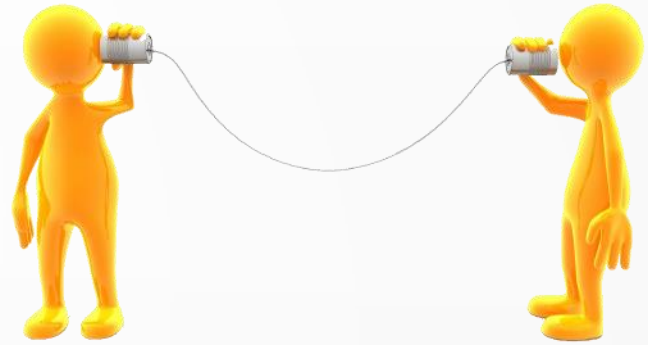
1. **Support Patient, Family & Caregiver**
2. **Patient, Family & Caregiver Education**
3. **Interprofessional Communication & Discharge Planning**
4. Community Reintegration
5. Transition of Patients to Long-Term Care

Providing Patient and Family-Centred Care Across all Transition Points

Patient, Family, & Caregiver Support & Education

- Occurs across transition points
- Assess needs, goals & readiness
- Prepare for transitions through information sharing, education, skills training, psychosocial support, & awareness of community services
  - Consider telemedicine technology to increase access
- Assess understanding & retention of previously taught info
  - Consider post-discharge telephone follow-up
- Reassess when there is change

Communication between healthcare professionals & care settings is critical for patient safety & quality care



Patient Care Planning

Patient-centered, culturally appropriate care plan- a mechanism for transition

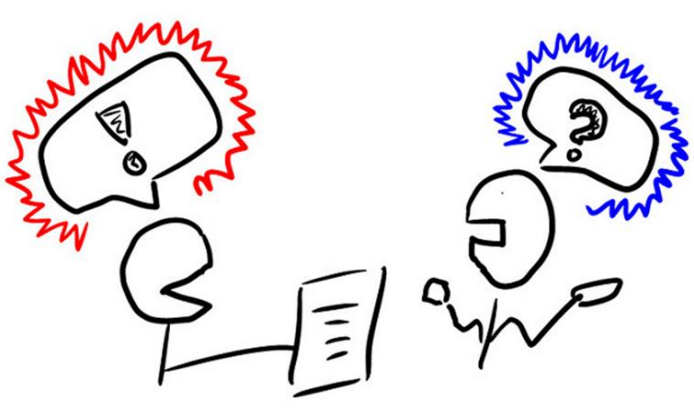
- Goals & Preferences 
- Medical, functional, rehabilitation, cognitive, communication, & psychosocial needs
- Self-management skills & confidence
- Community resources, support groups 
- Timely discussion 
- Initiate, review, & update

Handover Strategies

- Framework or structure to guide patient handovers or transitions
- Checklists, standardized exchange transfer forms (paper & electronic)
- Alert sheets to facilitate staffing levels
- Integrated electronic documentation systems
- Discharge preparation summary sheet (paper & electronic)
- Use of health information & communication technology e.g., electronic whiteboards for ED handovers

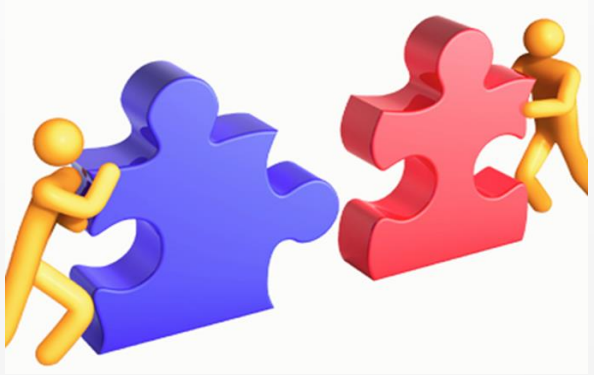
Discharge Planning

- Initiate ASAP
- Identify & address early possible discharge issues & needs (e.g., caregiver capacity)
- Formulate goal-oriented, collaborative plan for transition to rehabilitation, stroke prevention clinic, community
  - Include identification key contacts & healthcare providers at next stage of care, appointments, treatments & contact info to re-access healthcare services



Relationships & Coordination

- Enhances system-wide approach & encourages shared development of improvement strategies such as care pathways, compatible technology, & standard documentation
- Minimizes challenges & complications for patients & families
- Stroke case managers +/or stroke system navigators reduce burden to health system



Resources

- Stroke Network of Southeastern Ontario Community and Long Term Care
- Stroke Network of Southeastern Ontario Community Supports (For Patients)
- Stroke Resources (SouthEasthealthline.ca)
- Taking Action for Optimal Community and Long-Term Stroke Care: A resource for healthcare providers
- Patient Oriented Discharged Summary (PODS) Toolkit
- RNAO Care Transitions
- Re-Engineered Discharge (RED) Toolkit-AHRQ
- UTMB Handbook of Operation Procedures: Patient Discharge Planning (includes Roles in Discharge Planning)

Box 1: Transitions of Care Checklist

Support for patient, families and caregivers may include:

- ☐ Written discharge instructions and recommendations that identify collaborative actions plans, follow-up care and goals
- ☐ Access to a designated contact person in the hospital or community for care continuity and queries
- ☐ Ongoing access to and advice from health and social service organizations appropriate to needs and stage of transition and recovery
- ☐ Links to and information about local community agencies such as stroke survivor groups, peer survivor visiting programs, meal provider agencies, and other services and agencies
- ☐ Shared decision making/participation regarding transitions between stages of care
- ☐ Counseling, preparation and ongoing assessment for adjustment to change of living setting, change in physical needs and increased dependency, change in social roles and leisure activities, impact on other family members (e.g., spouse or partner, children), loss of home environment, and potential resource issues
- ☐ Access to restorative care and active rehabilitation to improve and/or maintain function based on the individualized care plan
- ☐ Advance care planning, palliative care and end-of-life care as applicable
- ☐ Where possible, access to peer (survivor/family), who has experienced the transition and who can help the patient better understand the transition
- ☐ Accurate and up to date information about the next care setting, what the patient and family can expect, and how to prepare.

http://www.strokebestpractices.ca/wp-content/uploads/2013/10/box1.pdf