Common Core Elements for Rehab Stroke Care - updated as of July 11, 2012

Background: As part of the Toronto Stroke Flow Initiative, the Toronto Stroke Networks (TSNs) facilitated meetings with the GTA Stroke Nursing Leadership Committee to collectively develop common core elements for processes of care documents (e.g., stroke protocols, pathways, etc.). These common core elements were developed by stroke nursing leaders from 16 acute care and rehab organizations across the GTA, and reflect input from their interprofessional stroke teams, the Canadian Stroke Strategy's Canadian Best Practice Recommendations for Stroke Care (2010) and the Toronto Stroke Flow Recommendations. The TSNs and the GTA Stroke Nursing Leadership Committee have developed this document to promote a standardization of stroke care across the GTA, and to assist organizations with prioritization and implementation of stroke best practices.

	Assessment & Management	**Diagnostics**	**Activity & Therapy**	**Transitions of Care**
Admission Phase	• Admission FIM® Instrument to be completed within 72 hours of admission to rehab (FIM® Instrument score will determine target discharge date based on the rehab patient group (RPG)). • Initial assessment by the interprofessional team within 24-48 hours (OT, PT, SLP, Physiatry, RN or RPN, pharmacy and RD) – this initial assessment should include: vital signs, the neurological exam, skin integrity, DVT, bowel and bladder continence, pain, fluid and	***For Ischemic Stroke:*** • Holter monitor for 48 hours or longer (if intermittent atrial fibrillation is suspected). • Carotid Dopplers if not done in acute care • 2-D Echo or Transesophageal Echo (TEE) • Hematology bloodwork • Follow-up CT for hemorrhagic strokes ~ 4 weeks later.	• Continuation of early mobilization (mobilization should start within 24 hours of symptom onset). • Establishing goals for persons with stroke – encouraging persons with stroke and their families/caregivers to be involved in the goal setting process. • Based on the initial assessment, provision of goal-based therapies as tolerated; tasks should be task-relevant, repetitive, and novel. • Therapy should be a	**A) Education for persons with stroke and their families or caregivers:** Education to include: • Education materials that were provided in acute care. • Information about the rehab program, services, roles of each team member, and other supports. • Goal-setting process • Plan of care over LOS • Advanced care directives

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Admission Phase (cont'd)	nutrition, safety risk and ability to learn, mobility, activities of daily Living (ADLs), instrumental activities of daily living (IADLs), attention, perception and cognition, behaviours, depression screening, swallowing and communication, social and home environment situations, etc. • Assessment of goals for persons with stroke. • Fall risk screening within 24 hours of admission. • An individualized falls prevention plan in place (within 72 hours) that can be	***For Hemorrhagic Stroke:*** • CT/angiogram upon admission.	minimum of 3 hrs of direct task-specific therapy by the interprofessional stroke team for a minimum of 5 days per week. • Inclusion of therapies as per the falls prevention plan. • Provision of bedside exercises that includes involvement of persons with stroke and their families/caregivers. • Provision of appropriate assistive devices or gait aids. • Assessment of sitting tolerance to determine a sitting schedule. • Introduction of a Discharge Planner or	• Expected LOS or milestones • Mechanism for family meetings • Information about stroke • Identification of co-morbid conditions (e.g., diabetes) and potential complications (related to skin, bladder / bowel, swallowing, nutrition, falls, depression, caregiver fatigue, etc.) and its management • Impact of co-morbidities on rehab • Transition Improvement for Continuity of Care (TICC) 'Stroke Passport'

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Admission Phase (cont'd)	modified based on clinical changes and/or the occurrence of a fall). • Swallowing assessment by SLP within 48 hours of admission to determine feeding options (oral diet vs. NG feed or enteral feed). • Communication assessment by SLP. • Assessment and management of co-morbidities. • A process to communicate initial assessment findings to the stroke team. • Use of standardized and valid assessment tools (e.g., Berg Balance Scale,		SW who is involved in discharge planning. • A process to communicate to the team of any potential barriers for discharge (e.g., house renovation delays, changes in family supports or finances). • Arranging for the first family meeting with the team (usually coordinated by the SW).	• Peer support resources • Any information that persons with stroke and their families/caregivers need to know or want to know (e.g., housing, environment). **B) Discharge planning and communication:** • Assessing the goals for persons with stroke. • Rehab team to connect with the point-person from acute care. • Rehab to follow-up with transfer documents from acute care (transfer documents should include information regarding follow-up appointments, interprofessional team notes, etc.).

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Admission Phase (cont'd)	Chedoke-McMaster Stroke Assessment, FIM® Instrument, MoCA©, etc.). • Arranging for an audiology and dental appointment. • Arranging for a sleep study appointment if the person with stroke has sleep apnea. • Advanced care planning discussion or assessment.			• Team to determine estimated discharge date based on RPGs - target discharge date communicated to the person with stroke and his/her family or caregiver. • Interprofessional team to complete initial assessments within 24 to 48 hours (includes goal setting). • Team to meet weekly once per week for rounds. • Access to appropriate diagnostics to facilitate early transfer to rehab. • FIM® Instrument score within 72 hours of admission. • Linkage to rehab SW or Admission

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Admission Phase (cont'd)				Coordinator early. • Assessment of substitute decision maker or POA. • Access to GP/Primary Health Care. • Advanced care planning.

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Interim Phase	• Re-assessing of goals for persons with stroke. • Ongoing re-assessment and management as mentioned above. • For moderate or severe strokes, re-assessments at least once per week by the interprofessional stroke team; after 4 weeks, the stroke team can re-assess as needed. • Consideration for equipment needs and finances. • Consideration for self medication education and training • Assessment to determine if the person with stroke is	• Bloodwork: CBC, lytes, liver enzymes, fasting glucose, glucose tolerance test (GTT), urea, HbA1c, etc. • Bladder scan tests for neurogenic bladder concerns. • Videofluoroscopy swallowing study • A sleep study if sleep apnea is suspected. • EEG if seizure activity is suspected. • EMG if spasticity is evident. • Continuous BP monitoring. • Leg dopplers based on signs and symptoms. • Chest x-ray based on signs and symptoms.	• Re-assessment of goals for persons with stroke. • A communication process that involves persons with stroke and their families/caregivers in the care planning. • Based on the initial assessment, provision of goal-based therapies as tolerated; tasks should be task-relevant, repetitive, and novel. • Progression of activity, ADL and mobility exercises as tolerated. • Therapy should be a minimum of 3 hrs of direct task-specific therapy by the interprofessional stroke team for a	**A) Education for persons with stroke and their families or caregivers:** • Follow-up with the educational needs for persons with stroke and their families or caregivers (as mentioned above). • Education on assistive device prescriptions (e.g. wheelchair prescription if warranted). • Education on community rehab services, CCAC and community supports. **B) Discharge planning and communication:** • Reviewing the goals and progress for

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Interim Phase (cont'd)	ready for a day or weekend pass. • If appropriate, initiation of the outpatient referral. • Consideration for persons with stroke and their families/caregivers to be involved in the care planning and discharge planning.		minimum of 5 days per week. • Inclusion of therapies as per the falls prevention plan. • Consulting with wellness partners or recreational therapy to provide social programs for persons with stroke. • Prior to a day pass or weekend pass, assessing the person with stroke's ability to perform car transfers and negotiate stairs. In addition, assessing for assistive devices to use during the day pass or weekend pass. • Continuing with discharge planning; home safety assessment by OT/PT	persons with stroke. • Family meeting to be coordinated by the team (communication of discharge plans). • Assessment of self management (e.g., medications). • Assessment of the equipment needs and home supports. • Initiation of referrals to community services. • Introduction of community resources or CCAC and referral to CCAC (Home First program) if appropriate. • Referral to convalescent care or outpatient rehab if appropriate.

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Interim Phase (cont'd)			if needed • To facilitate discharge planning, liaising with the SW or discharge planner regarding family meetings. • Interprofessional team to participate in family meetings to facilitate team communication with persons with stroke and their families or caregivers and to facilitate discharge.	• Determination of discharge requirements (e.g.,home renovations). • Establishment of caregiver support, and patient/family education. • If home is the discharge destination, trial of weekday/weekend passes. • Scheduling and follow-up with the secondary stroke prevention clinic or other medical appointments.

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Prior-to-Discharge Phase	• Home safety assessment by OT/PT. • Discharge FIM® Instrument to be completed by interprofessional team within 72 hours prior to discharge. • Assessing the person with stroke's understanding regarding medications and progress. • Assessing the person with stroke's support system (considerations for community re-engagement).	• Same as above • A process in place to communicate diagnostic findings to the primary care physician, specialists in the community, and the secondary stroke prevention clinic.	• Re-assessment of goals for persons with stroke. • Provision of appropriate assistive devices needed for discharge to the community. • Arrangement for outpatient referrals (if appropriate) and medical appointment follow-up. • Arrangement for community follow-up (e.g., community navigator). • Connecting the person with stroke to community supports, peer support programs, etc. • Prior to discharge or on the day of	• Follow-up with the education needs for persons with stroke and their families or caregivers (as mentioned in the admissions and interim phases). • Education on depression – signs & symptoms and how to get help. • Education on self management (e.g., finances, self meds, ADL's, etc.). • Education for caregiver support and community supports after discharge (e.g., the TICC Stroke Passport). • Education on what to talk about with his

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Prior-to-Discharge Phase (cont'd)			discharge, a discharge summary should be provided to CCAC (if appropriate), outpatient rehab services (if appropriate), the primary care physician, specialists in the community, the secondary prevention clinic, persons with stroke, and their families/caregivers.	or her primary care physician. **B) Discharge planning and communication:** • Review of the goals and progress for persons with stroke. • Review of equipment needs and home supports. • If the target discharge date is not being met (as determined by the FIM® Instrument score), a second target discharge date should be discussed with the team and communicated to the person with stroke and his/her family or caregiver. • Determination of ALC

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Prior-to-Discharge Phase (cont'd)				status • A communication process in place to discuss discharge planning with the interprofessional team, persons with stroke and their families or caregivers (e.g., arrangement for another family meeting if necessary) • Final arrangements for CCAC, convalescent care, or outpatient rehab if appropriate. • Final arrangements for community services, and transportation services if appropriate. • Establishment of a point-person in the community.