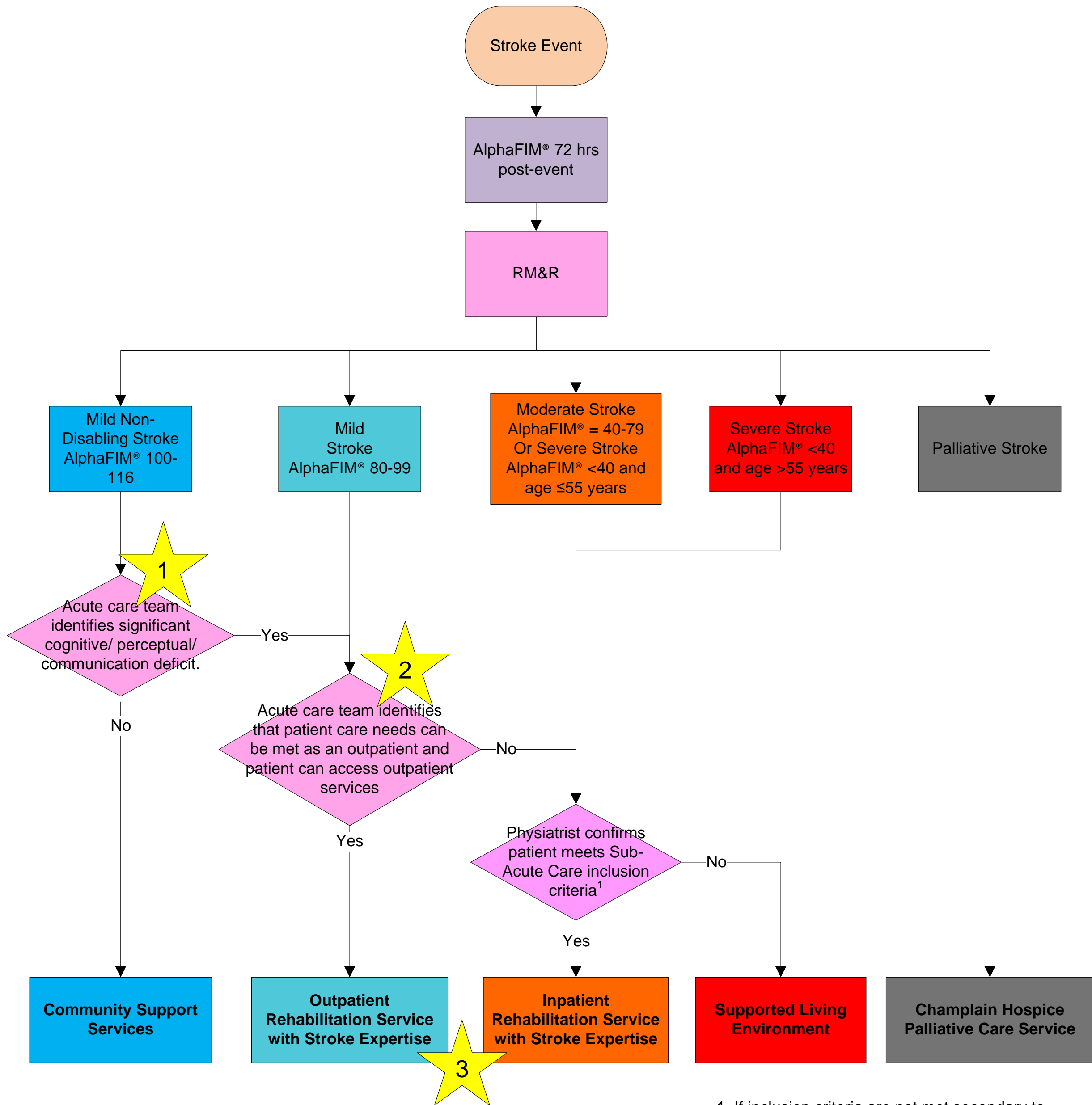
Regional Stroke Network
Réseau Régional des AVC
CHAMPLAIN

Ontario Stroke System
Fewer strokes. Better outcomes.

CHAMPLAIN REGIONAL STROKE REHABILITATION SYSTEM

The following future state process map (*patient flow algorithm)* for the Champlain Regional Stroke Rehabilitation System defines publicly funded sub-acute stroke service tiers with consistent and regionally defined admission criteria. Additional details required to implement the patient flow algorithm are included in this document. Use the stars and numbers as reference to finding related documents.



1. If inclusion criteria are not met secondary to medical instability then the patient will be reassessed by the physiatrist within 72 hours of the acute care team confirming a stable medical status.

IDENTIFYING DEFICITS IN MILD STROKE PATIENTS:
A PROCESS GUIDE FOR ACUTE STROKE UNITS

A patient who suffers a mild stroke may have communication, cognitive, or perceptual deficits that are not obvious but that may have a great impact on their functioning once they return to normal life. Because these mild stroke patients would otherwise be sent home without services, it is critical to identify whether deficits exist while they are still in the acute setting so that they can be referred to the appropriate sub-acute stroke service. The recommended process is outlined here:

COMMUNICATION DEFICIT

SPEECH-LANGUAGE PATHOLOGY SERVICES SHOULD BE CONSULTED IN ANY OF THE FOLLOWING SITUATIONS:

1. Stroke patient presents with aphasia and/or dysarthria as initial symptoms.
2. Stroke patient scores ≥ 1 on *Best Language* and/or *Dysarthria* items on NIHSS.
3. Stroke patient will be discharged directly to their home environment within 72 hours of admission.
4. Stroke patient scores ≥ 80 on AlphaFIM®.

The Speech-Language Pathologist will complete a communication assessment to determine whether deficits in communication exist.

COGNITIVE OR PERCEPTUAL DEFICIT

All stroke patients will be screened using the Montreal Cognitive Assessment (MoCA) within 24 to 48 hours of admission to acute care.

OCCUPATIONAL THERAPY SERVICES SHOULD BE CONSULTED IN ANY OF THE FOLLOWING SITUATIONS:

1. Stroke patient scores ≥ 1 on *Visual* and/or *Extinction and Inattention* items on the NIHSS.
2. Stroke patient will be discharged directly to their home environment within 72 hours of admission.
3. Stroke patient scores ≥ 80 on AlphaFIM®.

The Occupational Therapist will complete assessments to determine whether cognitive or perceptual deficits exist. The Trails A & B and a shape cancellation test (e.g. Star Cancellation, Line Cancellation) are recommended assessments.

Patient Care Needs Can be Met as Outpatient and Patient Can Access Outpatient Services

It is important to ensure that patients are able to return to their home environment and that they are able to access the outpatient stroke rehabilitation services to which they have been referred before they are discharged from acute care. The recommendations and questions that follow should be used to determine whether the patient is a suitable candidate for outpatient stroke rehabilitation services or if another sub-acute stroke service should be considered.

Process for Acute Stroke Units:

Does the patient meet the General Inclusion Criteria for all Sub Acute Care as defined in Appendix A of the Champlain Regional Stroke Rehabilitation System Project Charter? If yes, continue.

The acute care team, patient, and family/caregiver/other should make every effort to address any barriers to the patient accessing outpatient stroke rehabilitation services (e.g. finding alternate transportation if a family member is unable to help). **If, after exhausting all options to address barriers, the acute care team answers "no" to either of the questions below, the patient should be referred to inpatient stroke rehabilitation services** as either (a) their care needs cannot be met as an outpatient, or (b) they are unable to access outpatient stroke rehabilitation services.

1) Do the patient and family/caregiver agree that the patient access reliable transportation to and from the outpatient stroke rehabilitation service?

2) Does the patient have the stamina to participate in the demands and schedule of the outpatient stroke rehabilitation service (minimum of 45 minutes per day 2-3 times per week) and to tolerate travel time to and from the service? A travel time of <30 minutes has identified by the Ontario Stroke Network as a guideline to access outpatient services.

These service standards are supplementary to the Champlain Regional Stroke Rehabilitation System and Patient Flow Algorithm and should be used to guide the provision of inpatient stroke rehabilitation within the Champlain region. These service standards are reflective of the Canadian Best Practice Recommendations for Stroke Rehabilitation (2013) and Quality Based Procedures Clinical Handbook for Stroke (September 2013).

The administrator responsible for the inpatient stroke rehabilitation service, together with the manager, may review these service standards on an annual basis with the Champlain Regional Stroke Network to develop a plan for improvement with the support of the Rehabilitation Coordinator. Recommended methods of verification for each standard are provided, as appropriate.

1. Interprofessional Stroke Rehabilitation Team

Stroke rehabilitation in the inpatient setting is to be provided by an interprofessional rehabilitation team with stroke expertise.

The core team members are:

- **Physician** - The Physician role must be occupied by a Physiatrist, Neurologist, or other physician with expertise and core training in stroke rehabilitation.
- **Nurse** - At least one nurse must be a Registered Nurse (RN).
- **Physical Therapist**
- **Occupational Therapist**
- **Speech Language Pathologist**
- **Social Worker**
- **Pharmacist**
- **Recreation Therapist**

In addition to the core members, the inpatient stroke rehabilitation service should have the ability to consult the following disciplines, should one or more be required for the patient's rehabilitation:

- **Psychologist**
- **Dietitian**

Expertise and core training in stroke rehabilitation is expected for all members of the core team (see Section 2.1 for more information) [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

2. Stroke Expertise

The Canadian Best Practice Recommendations for Stroke Care say that the interprofessional stroke rehabilitation team should have stroke expertise. This section provides the Service Standards Working Group's interpretation of *stroke expertise* and includes a list of available training/education resources, which can help team members gain stroke expertise. There is also an emphasis on continuing education.

2.1. Core Skill Sets, Knowledge & Training

The management of the inpatient stroke rehabilitation service is responsible for verifying that each member on the interprofessional stroke rehabilitation team has achieved or learned the appropriate items below (in Table 1). It is the responsibility of each member on the team to ensure that they are aware of and have the appropriate core skill sets, knowledge, and training outlined in Table 1.

All members of the interprofessional stroke rehabilitation team will:

TABLE 1

Core Skill Set, Knowledge, or Training	Recommended Learning & Resources	Method of Verification/Other Relevant Information about Resource
Be knowledgeable about the disease/condition of stroke, including basic anatomy, deficits, and recovery.	i) Shared Learning Objectives for Stroke Care (SLOSC) ii) Hemispheres Stroke Competency Series iii) Educational events: - CRSN Educational Events - OSN Rounds or other webcast/webinar series - Other stroke-related discipline-specific education series	i) Use of SLOSC for needs self-assessment and to set learning objectives. ii) Participant receives a course completion certificate and/or continuing education certificate for completing the series. iii) For items iii through v – each team member should participate in at minimum one of these types of education sessions per year. The person's *professional portfolio*^ will include a list of education sessions attended. ***Verification*** for CRSN events attended can be obtained through the Education Database.
Be aware of and follow Canadian Best Practices Recommendations for Stroke Care, in Rehabilitation specifically. **Be aware of the EBRSR (Evidence-Based Review of Stroke Rehabilitation) website and use, as needed.**	i) OSN presents videoconferences when a best practice guideline is released or updated. ii) Interprofessional team can review the guidelines as a group or individually.	i) Each team member should attend or watch archived webcast of these presentations. Verification comes from the OTN/OSN sign-in confirmations. ii) Team member signs off that they have reviewed and understand the guideline.
Be aware of and be able to provide some supported communication for patients with aphasia. ***Only the inpatient stroke rehabilitation service's SLP(s) is/are required to have formal training on interacting with stroke patients with aphasia.***	i) Inpatient stroke rehabilitation service SLP can provide information about supportive communication to all core team members. ii) Supported Conversation for Adults with Aphasia (SCA) ▪ Self-directed learning module (from the Aphasia Institute) ▪ Training offered by an SLP who has participated in *train the trainer* program for SCA iii) Workshop on communication deficits post-stroke	i) Core team members have learned about supported conversation techniques for stroke patients with aphasia. ii) Inpatient stroke rehabilitation Service SLP(s) has participated in SCA training. iii) SLP(s) has attended a communication workshop (not mandatory). Note that the inpatient stroke service's SLP(s) can provide information the core team about

		supportive communication for stroke patients with aphasia.
Understand how to administer, interpret, and apply validated assessment tools.	Lists of recommended assessment tools: ▪ Best Practice Recommendations Table 5.1 ▪ StrokeEngine	Team members are familiar with and use the recommended tools when appropriate.
Have knowledge of standard outcome measures recommended for use in the Champlain region, especially domain-specific outcome measures. **Use, as appropriate, standard outcome measures.** **Be aware of the StrokeEngine website where additional assessments and tools can be found.**	Examples of recommended outcome measures: i) Chedoke McMaster – McMaster University offers a training workshop ii) ASHA FCMs – training video available from CRSN iii) Berg Balance Scale (BBS) – no formal post-licensure training A complete list can be found on the Champlain Regional Stroke Network website.	i) Certificate from McMaster ii) SLP has watched the video iii) Team members are familiar with and use the BBS when appropriate Team members regularly use these outcome measures for stroke patients.
Be trained on or be familiar with the Functional Independence Measure (FIM) instrument*.	The Canadian Institute for Health Information (CIHI) runs a *train the trainer* program for the FIM instrument. A new employee would be trained by a staff member at their organization who participated in the train the trainer program.	Individual will receive a certificate after successful completion of FIM training. CIHI recommends annual recertification, although it is not compulsory. Facilities may decide whether clinicians are to be recertified on an annual basis.
Be trained on or be familiar with the Montreal Cognitive Assessment (MoCA)*.	MoCA website includes the test as well as instructions for use. There is no formal post-licensure training.	Team members are familiar with and use the MoCA where appropriate.
Have knowledge about interprofessional team functioning.	Workshops or communication / collaboration events within your organization. OSN Interprofessional Collaboration references	Group's attendance (together) at a workshop. Team members are aware of the roles of other team members. Team has implemented interprofessional functioning model in their practice.

^It is expected that all members of the interprofessional rehabilitation team maintain a professional portfolio for their college, which details the education they have taken throughout the year.
*Not all staff on the interprofessional stroke rehabilitation team will need to administer the FIM or the MoCA, however, it is required that these uncertified staff are knowledgeable about these two assessments.

2.2. Continuing Education

Continuing education is a key consideration for the interprofessional stroke rehabilitation team due to the frequent emergence of new evidence that results in changes to best practices in rehabilitation.

- The learning needs of the team are assessed on an annual basis with gaps in knowledge addressed as they are identified.
- The team is to be engaged in continuing education year-round.
- The team follows the institution or organization's policies for continuing education, which can be verified against said policy.

Verification – Evidence that the interprofessional stroke rehabilitation team members are participating in continuing education can be found in each team members' professional portfolio.

2.3. Treatments and Therapies

The clinician may apply whatever **evidence-based** approach to therapy/treatment they consider to be appropriate for the patient so long as the following three elements are incorporated:

(1) Treatment/therapy is be direct and task/goal specific.
(2) Treatment/therapy includes repetitive and intense use of novel tasks that challenge the patient to gain the skills needed to perform functional tasks and activities.
(3) The team promotes the practice and transfer of skills to the patient's daily routine [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

The Canadian Best Practice Recommendations for Stroke Care provide treatments/therapies that are appropriate for stroke patients. This service standard will not prescribe specific treatments/therapies, trusting that each member of the interprofessional stroke rehabilitation team is knowledgeable in their field of practice and able to provide appropriate rehabilitation.

Verification – Treatment/therapy provided is evidence-based and incorporates the three elements of therapy listed above. A chart audit may be completed to verify this.

3. Frequency and Intensity of Inpatient Stroke Rehabilitation Services

Stroke patients are to receive rehabilitation therapies of appropriate intensity and duration, individually designed to meet their needs for optimal recovery and tolerance levels. The patient will receive therapy that is direct and task/goal specific and provided on a one-to-one basis by the interprofessional stroke rehabilitation team for a **minimum** of three (3) hours per day, five (5) days per week [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

Therapy/Rehabilitation Included in the three hours of therapy:

- Three hours of therapy per day must be provided to the stroke patient, regardless of the number of services required (e.g. if the patient requires only occupational therapy and communication therapy, the two disciplines must make up the entire three hours) [Quality-Based Procedures: Clinical Handbook for Stroke, 2013].
- Physiotherapists, Occupational Therapists, and Speech-Language Pathologists (regulated rehabilitation professionals) should provide the bulk of the three hours of therapy required per day [Recommendation by Service Standards Working Group, 2014].
- So long as it is direct and task/goal specific, rehabilitation therapy provided by assistants (e.g. Physiotherapy Assistant, Rehab Assistant) is included in the three hours [Recommendation by Service Standards Working Group, 2014].

Therapy considered adjunct to (not included in) the three hours of direct, task/goal specific therapy:

- Therapy provided by Nursing and other disciplines (e.g. Recreation Therapist) in the form of activity of daily living (ADL) rehabilitative therapy is not included in the three hours of direct, task/goal specific therapy per day [Recommendation by Service Standards Working Group, 2014].

- Group therapy (i.e. many stroke patients participating in therapy led by one or more rehabilitation professional) is not included in the three hours of therapy per day [Recommendation by Service Standards Working Group, 2014].

Verification – Workload measurement systems may be used to verify the amount of direct, task/goal-specific therapy provided to the patient.

4. Service Delivery

4.1. Staffing Ratios for Inpatient Stroke Rehabilitation

Staffing ratios are sufficient to support the frequency and level of intensity of rehabilitation outlined above. [Recommendation by Service Standards Working Group, 2014]. Although they are recommended by some resources, this service standard will not prescribe staffing ratios for inpatient rehabilitation. Instead, this service standard advises that acceptable staffing ratios are those that enable the inpatient stroke rehabilitation service to provide quality rehabilitative care to its stroke patients, allowing patients to meet their rehabilitation goals, achieve functional gains, and experience good outcomes.

4.2. Location of Inpatient Stroke Rehabilitation

The inpatient stroke rehabilitation unit is geographically defined [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013]. Where admission to a stroke rehabilitation unit is not possible, inpatient rehabilitation is provided on a general rehabilitation unit (i.e. where interprofessional care is provided to patients disabled by a range of disorders including stroke) where a physician with expertise/core training in stroke rehabilitation is available (on the unit or by consultation) is the next best alternative [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

4.3. Interprofessional Team Meetings

Interprofessional rehabilitation team meetings will be held at least once per week. During the meeting, the patient's rehab goals are set, problems are identified, progress is monitored, and support after discharge is planned [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

4.4. Discharge from Inpatient Stroke Rehabilitation

Patients discharged from inpatient stroke rehabilitation often require ongoing support once they return to their home environment. A pre-discharge needs assessment will be conducted for the stroke patient before discharge from the inpatient stroke rehabilitation service. The Canadian Best Practice Recommendations for Stroke Rehabilitation (2013) section 5.3.vii provides elements of discharge planning for consideration.

This document will be updated as new evidence, best practices, and Quality Based Procedures information are released. This document was last updated on June 3, 2014. Before using this resource, check for the most recent version on the Rehab page of the Champlain Regional Stroke Network website:

www.champlainregionalstrokenetwork.org

SERVICE STANDARDS FOR OUTPATIENT REHABILITATION SERVICE WITH STROKE EXPERTISE

These service standards are supplementary to the Champlain Regional Stroke Rehabilitation System and Patient Flow Algorithm and should be used to guide the provision of outpatient stroke rehabilitation within the Champlain region. These service standards are reflective of the Canadian Best Practice Recommendations for Stroke Rehabilitation (2013) and Quality Based Procedures Clinical Handbook for Stroke (September 2013).

The administrator responsible for the outpatient stroke rehabilitation service, together with the manager, may review these service standards on an annual basis with the Champlain Regional Stroke Network to develop a plan for improvement with the support of the Rehabilitation Coordinator. Recommended methods of verification for each standard are provided, as appropriate .

1. INTERPROFESSIONAL STROKE REHABILITATION TEAM

Stroke rehabilitation in the outpatient setting is to be provided by an interprofessional rehabilitation team with stroke expertise.

The core team members are:

- **Physician** - The Physician role must be occupied by a Physiatrist, Neurologist, or other physician with expertise and core training in stroke rehabilitation.
- **Nurse** - At least one nurse must be a Registered Nurse (RN).
- **Physical Therapist**
- **Occupational Therapist**
- **Speech Language Pathologist**
- **Social Worker**

In addition to the core members, the outpatient stroke rehabilitation service must have the ability to consult the following disciplines, should one or more be required for the patient's rehabilitation:

- **Pharmacist**
- **Recreation Therapist**
- **Psychologist**
- **Dietitian**
- **Vocational Counselor**

Expertise and core training in stroke rehabilitation is expected for all members of the core team (see Section 2.1 for more information).

2. STROKE EXPERTISE

The Canadian Best Practice Recommendations for Stroke Care say that the interprofessional stroke rehabilitation team should have stroke expertise. This section provides the Service Standard Working Group's interpretation of *stroke expertise* and includes a list of available training/education resources, which can help team members gain stroke expertise. There is also an emphasis on continuing education.

2.1. Core Skill Sets, Knowledge & Training

The management of the outpatient stroke rehabilitation service is responsible for verifying that each member on the interprofessional stroke rehabilitation team has achieved or learned the appropriate items below (in Table 1). It is the responsibility of each member on the team to ensure that they are aware of and have the appropriate core skill sets, knowledge, and training outlined in Table 1.

All members of the interprofessional stroke rehabilitation team will:

TABLE 1

Core Skill Set, Knowledge, or Training	Recommended Learning & Resources	Method of Verification/Other Relevant Information about Resource
Be knowledgeable about the disease/condition of stroke, including basic anatomy, deficits, and recovery.	i) Shared Learning Objectives for Stroke Care (SLOSC) ii) Hemispheres Stroke Competency Series iii) Educational events: - CRSN Educational Events - OSN Rounds or other webcast/webinar series - Other stroke-related discipline-specific education series	i) Use of SLOSC for needs self-assessment and to set learning objectives. ii) Participant receives a course completion certificate and/or continuing education certificate for completing the series. iii) For items iii through v – each team member should participate in at minimum one of these types of education sessions per year. The person's *professional portfolio*^ will include a list of education sessions attended. ***Verification*** for CRSN events attended can be obtained through the Education Database.
Be aware of and follow Canadian Best Practices Recommendations for Stroke Care, in Rehabilitation specifically. **Be aware of the EBRSR (Evidence-Based Review of Stroke Rehabilitation) website and use, as needed.**	i) OSN presents videoconferences when a best practice guideline is released or updated. ii) Interprofessional team can review the guidelines as a group or individually.	i) Each team member should attend or watch archived webcast of these presentations. Verification comes from the OTN/OSN sign-in confirmations. ii) Team member signs off that they have reviewed and understand the guideline.
Be aware of and be able to provide some supported communication for patients with aphasia. ***Only the outpatient stroke rehabilitation service's SLP(s) is/are required to have formal training on interacting with stroke patients with aphasia.***	i) The outpatient stroke rehabilitation service SLP can provide information about supportive communication to all core team members. ii) Supported Conversation for Adults with Aphasia (SCA): ▪ Self-directed learning module (from the Aphasia Institute) ▪ Training may be offered by an SLP who has participated in *train the trainer* program for SCA. iii) Workshop on communication deficits post-stroke.	i) Core team members have learned about supported conversation techniques for stroke patients with aphasia. ii) The outpatient stroke rehabilitation service SLP(s) has participated in SCA training. iii) SLP(s) has attended a communication workshop (not mandatory). Note that the outpatient stroke Service's SLP(s) can provide

		information to the core team about supportive communication for stroke patients with aphasia.
Understand how to administer, interpret, and apply validated assessment tools	Lists of recommended assessment tools: ▪ Best Practice Recommendations Table 5.1 ▪ StrokeEngine	Team members are familiar with and use the recommended tools when appropriate.
Have knowledge of standard outcome measures recommended for use in the Champlain region, especially domain-specific outcome measures. **Use, as appropriate, standard outcome measures.** **Be aware of the StrokeEngine website where additional assessments and tools can be found.**	Examples of recommended outcome measures: i) Chedoke McMaster – McMaster University offers a training workshop ii) ASHA FCMs – training video available from CRSN iii) Berg Balance Scale (BBS) – no formal post-licensure training A complete list can be found on the Champlain Regional Stroke Network website.	i) Certificate from McMaster ii) SLP has watched the video iii) Team members are familiar with and use the BBS when appropriate Team members regularly use these outcome measures for stroke patients.
Be trained on or be familiar with the Functional Independence Measure (FIM) instrument*.	The Canadian Institute for Health Information (CIHI) runs a *train the trainer* program for the FIM instrument. A new employee would be trained by a staff member at their organization who participated in the train the trainer program.	Individual will receive a certificate after successful completion of FIM training. CIHI recommends annual recertification, although it is not compulsory. Facilities may decide whether clinicians are to be recertified on an annual basis.
Be trained on or be familiar with the Montreal Cognitive Assessment (MoCA)*.	MoCA website includes the test as well as instructions for use. There is no formal post-licensure training.	Team members are familiar with and use the MoCA where appropriate.
Have knowledge about interprofessional team functioning	Workshops or communication / collaboration events within your organization or department. OSN Interprofessional Collaboration references.	Group's attendance (together) at a workshop. Team members are aware of the roles of other team members. Team has implemented interprofessional functioning model in their practice.

^It is expected that all members of the interprofessional rehabilitation team maintain a professional portfolio for their colleges, which details the education they have taken throughout the year.
*Not all staff on the interprofessional stroke rehabilitation team will need to administer the FIM or the MoCA, however, it is required that these uncertified staff are knowledgeable about these two assessments.

2.2. Continuing Education

Continuing education is a key consideration for the interprofessional stroke rehabilitation team due to the frequent emergence of new evidence that results in changes to best practices in stroke rehabilitation.

- The learning needs of the team are assessed on an annual basis with gaps in knowledge addressed as they are identified.
- The team is to be engaged in continuing education year-round.
- The team follows the institution or organization's policies for continuing education, which can be verified against said policy.

Verification – Evidence that the interprofessional stroke rehabilitation team members are participating in continuing education can be found in each team members' professional portfolio.

2.3. Treatments and Therapies

The clinician may apply whatever **evidence-based** approach to therapy/treatment they consider to be appropriate for the patient as long as the following three elements are incorporated:

(1) Treatment/therapy is be direct and task/goal specific.
(2) Treatment/therapy includes repetitive and intense use of novel tasks that challenge the patient to gain the skills needed to perform functional tasks and activities.
(3) The team promotes the practice and transfer of skills to the patient's daily routine [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

The Canadian Best Practice Recommendations for Stroke Care provide treatments/therapies that are appropriate for stroke patients. This service standard will not prescribe specific treatments/therapies, trusting that each member of the interprofessional stroke rehabilitation team is knowledgeable in their field of practice and able to provide appropriate rehabilitation.

Verification – Treatment/therapy provided is evidence-based and incorporates the three elements of therapy listed above. A chart audit may be completed to verify this.

3. Frequency and Intensity of Outpatient Stroke Rehabilitation Services

Stroke patients are to receive rehabilitation therapies of appropriate intensity and duration, individually designed to meet their needs for optimal recovery and tolerance levels. The patient will receive therapy that is direct and task/goal specific and provided on a one-to-one basis by the interprofessional stroke rehabilitation team.

Rehabilitation therapy in the outpatient setting will be provided primarily by Physiotherapists, Occupational Therapists, and Speech Language Pathologists. Assistants (e.g. Rehab Assistant, Physiotherapy Assistant) and other members of the interprofessional stroke rehabilitation team will also provide therapy, depending on the needs of the patient.

The amount of rehabilitation therapy provided is to be based on patient needs and goals. At a **minimum**, therapy should be provided **by each discipline (PT, OT, and/or SLP) the patient requires** for:

- 45 minutes per day up to 3 hours per day [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013];
- 2 to 3 days per week [The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario, 2012];
- 8 to 12 weeks [The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario, 2012].

Verification – Random chart audit/review of patient rehabilitation sessions.

4. Service Delivery

4.1. Staffing Ratios for Outpatient Stroke Rehabilitation Services

Staffing ratios are sufficient to support the frequency and level of intensity of rehabilitation outlined above [Recommendation by Service Standards Working Group, 2014]. Acceptable staffing ratios are those that enable the outpatient stroke rehabilitation service to provide quality rehabilitative care to its stroke patients, allowing patients to meet their rehabilitation goals, achieve functional gains, and experience good outcomes.

4.2. Team Meetings

Regular team meetings to discuss assessment of new clients, review client management, goals, and plans for discharge or transition are to occur in the outpatient stroke rehabilitation setting. Patients and families/caregivers are to be involved in the patient's management, goal setting, and transition planning, which may occur during team meetings [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

4.3. Time to First Appointment

Outpatient stroke rehabilitation services are responsible for admitting stroke patients to the program on a priority basis. When it is required by the patient, interdisciplinary outpatient stroke rehabilitation services should be available and provided within 48 and 72 hours of discharge from acute care and inpatient stroke rehabilitation, respectively [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

This document will be updated as new evidence, best practices, and Quality Based Procedures information are released. This document was last updated on June 2, 2014. Before using this resource, check for the most recent version on the Rehab page of the Champlain Regional Stroke Network website:

www.champlainregionalstrokenetwork.org