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Advancing the Ontario Stroke System

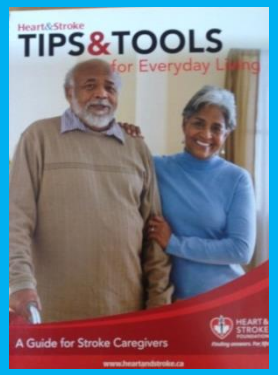
Stroke Best Practice Care Plans for Long Term Care

June 2016

Stroke Best Practice for Long-Term Care

2010

RAI-MDS LTC implementation completed.
Heart and Stroke Foundation of Ontario releases *Tips & Tools for Everyday Living*



2011 - 2012

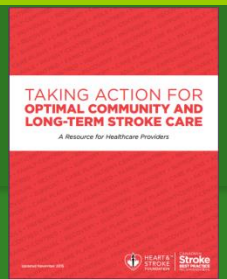
Stroke Care Plans developed by LTC & Ontario Stroke System reps and piloted in 4 LTC Homes

2012 - 2015

Stroke Care Plans implemented in LTC Homes across Ontario

2015

Heart and Stroke Foundation *Taking Action for Optimal Community & Long-Term Stroke Care* released



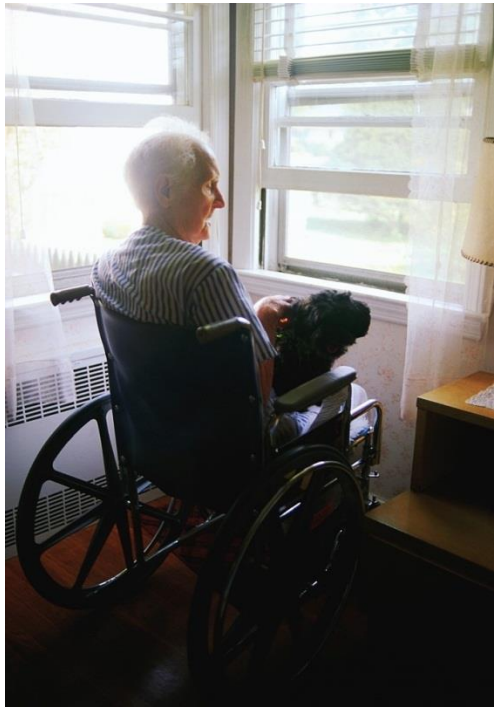
2015 - 2016

Stroke Care Plans updated and released March 2016

Stroke in Long Term Care

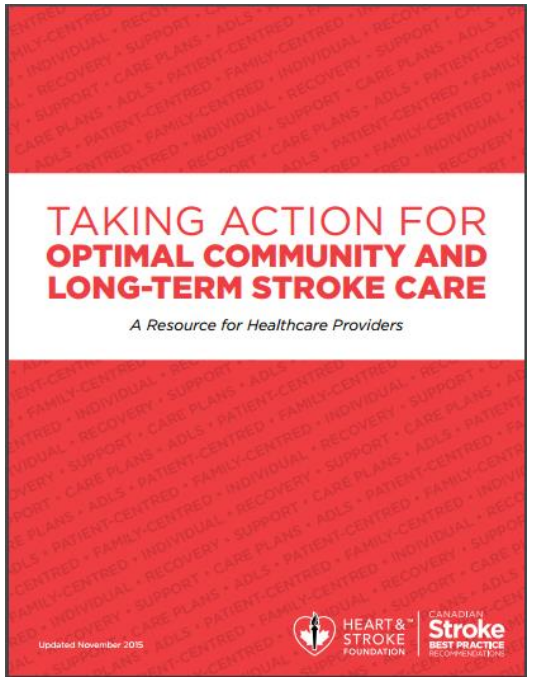
Of every 100 people who have a stroke:

- 15 die
- 10 recover completely
- ‘ 25 recover with a minor impairment or disability
- 40 are left with a moderate to severe impairment
- 10 are so severely disabled they require long-term care (Quality Based Procedures: Clinical Handbook for Stroke, 2015)
- 21.3% of residents in LTC have had a stroke (Continuing Care Reporting System, CIHI, 2014-15).
- Stroke is the third most common diagnosis in long-term care (Price Waterhouse Cooper 2001).



Taking Action for Optimal Community & Long-Term Stroke Care (TACLS)

- Developed by Heart & Stroke Foundation
- Released 2015
- Reflects the Canadian Stroke Best Practice Recommendations
- Evidence-based resource
- Provides guidance for the provision of best practice stroke care in LTC and community setting



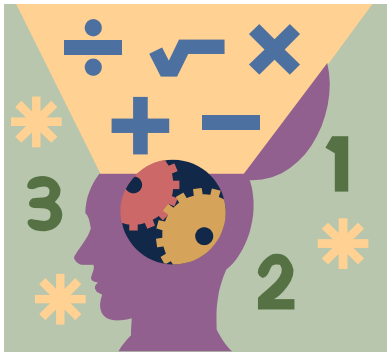
http://www.strokebestpractices.ca/wp-content/uploads/2016/01/HSF_F15_TACLS_booklet_EN_FINAL-LR_Linked-all-sections-23Dec15.pdf

Adding It Up

RAI MDS

\+ *Taking Action for Optimal Care in Community & Long Term Stroke Care (TACLS)*

= Best Practice Stroke Care Plans



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Project Progression

Initial Project 2010/11	Care Plan Update 2015/16
• Working groups included representatives from LTC and Ontario Stroke System • LTC reps from across Ontario including rural/urban settings and various disciplines (e.g. DOC, PSWs, RAI Coordinators) • 12 Stroke Care Plans based on the *Tips and Tools* resource were developed and linked to RAI MDS Outcomes Scales • Reviewed by Compliance Director, Retirement Home Regulatory Authority, Ministry of Health and Long Term Care	• Initial revisions by Regional Stroke Network Community & Long-Term Care Coordinators (CLTCs) • Revisions based on TACLS resource and changes in LTC practice/Regulations • Drafts to working group of LTC and CLTC reps • LTC reps included administrative, front line and RNAO LTC Best Practice Coordinators • Final revisions by CLTCs

The Stroke Care Plans

Stroke Care Plans

- Activities of Daily Living
- Behaviour Change
- Bladder and Bowel Continence
- Cognition
- Communication
- Depression
- Leisure
- Mobility, Positioning & Transfers
- Nutrition, Hydration & Swallowing
- Pain
- Perception
- Skin Care & Hygiene

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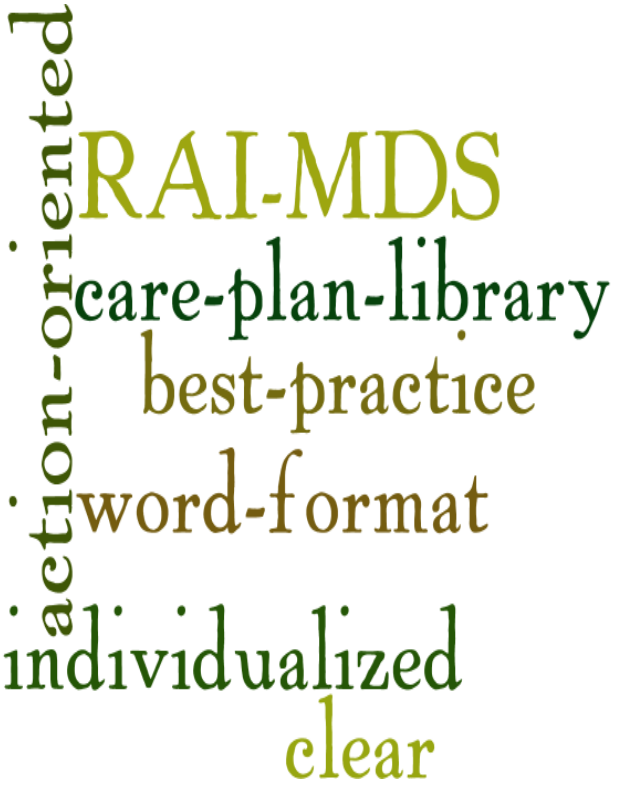
Stroke Care Plans for LTC - Format

Focus	Goal	Interventions	Accountability	Timelines
Uses PESS (problem, etiology, signs, symptoms).	SMART format written from the resident's perspective (e.g. what resident will do, look like, etc.), reflects the RAI-MDS Outcome Scales and includes prompts to individualize goals.	A restorative, interdisciplinary approach.	Specific team members must be identified for each intervention to reflect the care model and care team for each LTC Home.	Timelines should not automatically coincide with reassessments (i.e.q3months). Timelines are to be related to resident's goal or goal assessment.

Stroke Care Plans for LTC

- clear, action-oriented language
- word format to allow for individualization
- integration of plans in whole or embedded in existing plans
- relevant chapter(s) from *Taking Action for Optimal Community & Long Term Stroke Care*™ are referenced for each focus
- additional best practice resources are listed for each Care Plan



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STROKE CARE PLAN: PERCEPTION

All interventions must be implemented, monitored, evaluated and documented as per Home policy.
Any changes (improvements or deterioration) must be reported to the RN/RPN.

FOCUS	GOAL(S)	TIMELINES	INTERVENTIONS	ACCOUNTABILITY
Unilateral Spatial Neglect Resident has decreased awareness of affected side of body (unilateral spatial neglect) due to stroke as evidenced by bumping into things, missing food on left/right side of meal tray, losing way to room. *Chapter 4, Section 4.2 Taking Action for Optimal Community and Long Term Stroke Care, A Resource for Healthcare Providers (2015)*	Resident's ADL score will improve from___ to ___ Resident's safety will be improved by (specify): ▪ increased attention to affected side ▪ decreased episodes of bumping into objects on affected side ▪ decreased episodes of arm/hand dangling off the wheelchair or chair armrest ▪ decreased episodes of leg/foot dragging off the wheelchair footrest ▪ increased independence in finding all food items during meals ▪ less cueing required to find necessary objects/ items in cupboards/ drawers ▪ less assistance needed to find way around Home		Refer to occupational or physiotherapist for recommendations on how to best use the neglected limb in daily activities. Position or help the resident position the affected limb so they can see the limb Ensure hearing and visual aids are functioning and in place. Place items on the resident's unaffected side, so they are easy to find. Approach the resident from the unaffected side so they are aware of your presence. Gradually move to the affected side to bring resident's attention to the neglected side Assist resident to position the affected limb correctly. Place your hand on top of the resident's neglected limb or gently rub the limb to offer sensory feedback to help them notice the affected body part.	Registered Staff PSW/HCA/Recreation Staff PSW/HCA/Recreation Staff All staff interacting with resident. All staff interacting with resident. PSW/HCA/Recreation Staff PSW/HCA

Pilot of Care Plans 2011/12

- Four pilot sites were a mix of urban and rural facilities
- Positive results from pilot evaluation

"The opportunity to ensure that our care planning contained best practices and an evidence base was the foundation for us to move forward in this project."

– Pilot Home

Pilot Project: Evaluation

- 95.8% of respondents indicated that the stroke care plans enhanced their ability to care for stroke residents to varying degrees.
- Care plans on transfers and mobility, perception, cognition, pain and communication were found to be particularly useful.
- Pilot homes reported an increase awareness and uptake of best practice stroke care.

Pilot Project (2012): Feedback

"This resource (*Tips and Tools for Everyday Living)* has been an extremely beneficial tool which assisted staff to understand brain physiology, risk factors, stroke impact on life and how the care team can affect resident outcomes."

- Pilot Home

"Tips and Tools for Everyday Living provided an evidence based approach for team members to assist the stroke survivor to achieve the optimal wellness level and their full potential. Our staff repeatedly expressed the value of this resource."

- Pilot Home

Care Plan Implementation: 2012 – 2015

- Following pilot, Stroke Care Plans have expanded into additional LTC Homes including independent and corporate Homes
- Response to Stroke Care Plan implementation continues to be positive

"The development and roll out of the Stroke Care Plans across our organization has been very beneficial to not only the recipients of this very individualized care but also for the interdisciplinary teams providing the care. They have provided us with key areas of focus for those individuals who have experienced a stroke as well as measureable goals and interventions that can be tailored to individual residents." ~ March 2015

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Implementation Toolkit

Contents:

- Background
- Stroke Care Plans
- Implementation Tips
- Frequently Asked Questions
- Stroke Care Plans - PowerPoint Presentation

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Future Opportunities

- Explore research opportunities (e.g., impact of Care Plans on Depression Rating Scale).
- Initial discussions re adaptation of Care Plans to community setting.
- Explore opportunities to collaborate with software companies to integrate care plans into existing libraries.
- Expansion of plans to national basis.
- Collaborating with Accreditation Canada and the Commission on Accreditation of Rehabilitation Facilities (CARF)

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QUESTIONS

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CONTACT