

 C R E D I T • V A L L E Y <small>THE CREDIT VALLEY HOSPITAL</small>		CLINICAL PRACTICE GUIDELINE	PROFESSIONAL PRACTICE
TITLE: Stroke Care Rehabilitation Unit			
DATE OF ISSUE: 2005, 05	PAGE 1 OF 7	NUMBER: CPG 20-3	
SUPERCEDES: New	ISSUED BY: _____		
	TITLE: Chief of Medical Staff		
	ISSUED BY: _____		
	TITLE: President		

Purpose:

To provide guidelines in caring for the stroke survivor with impairments, activity limitations, and participatory restrictions and to assist stroke survivors to reach their optimal physical, mental and social functional level through patient focused partnership between the family, providers and the community. The primary focus of rehabilitation care is to improve the abilities of the stroke survivor and to facilitate independence and social integration.

Inclusion criteria:

1. The patient has been assessed by the acute care team and meets the following admission criteria for rehabilitation:
 - an established neurological diagnosis
 - acute phase of the illness is complete and the patient is medically stable
 - the patient has a functional deficit (s) requiring specialized assessment, therapeutic treatment, education, adaptation and training requiring a multidisciplinary approach
 - the patient is able to physically tolerate an active rehabilitation program and demonstrate potential for functional improvement
 - the patient must have sufficient cognitive and perceptual ability to participate in and understand the process of striving to attain goals
 - the patient must have a discharge plan which includes one of the following:
 - home
 - home with community or outpatient supports
 - application process initiated to retirement home, supportive housing, long term care facility or chronic care facility
2. Rehabilitation application forms are completed and signed by patient or family and Most Responsible Physician.
3. Application is approved by the rehabilitation admissions committee.

Exclusion criteria:

The patient has been assessed by the acute care team and meets the requirements for:

Home based programs –

- Mild stroke
- Able to manage in the home with support services
- Home is accessible or is being made accessible

Ambulatory rehabilitation: Rehabilitation Day Hospital or Neurology Outpatient Program –

- Mild stroke
- Able to manage in the home with support services
- Able to travel to the ambulatory rehabilitation program

Complex Continuing Care/Nursing Home –

- Catastrophic stroke – not expected to survive, comatose, may not leave hospital.
- Limited rehabilitation potential.

Definitions:**Stroke Rehabilitation Team –**

- Physician
- Registered Nurse
- Occupational Therapist
- Physiotherapist and Physiotherapy Assistant
- Speech Language Pathologist (SLP)
- Social Worker
- Therapeutic Recreationist
- Psychologist
- Pharmacist
- Registered Dietitian

Case Management – A system of health care delivery that coordinates interdisciplinary care services.

Case Manager – A member of the rehabilitation team chosen to work with a specific patient/family to facilitate a coordinated rehabilitation process.

Major Recommendations for the Management of Stroke Rehabilitation:**Principles of comprehensive stroke rehabilitation:**

- continuity of care throughout the continuum
- interdisciplinary care by experienced and dedicated professionals
- recognition and optimal management of co-morbidities and complications
- early goal directed treatment that enhances abilities and minimizes disabilities
- implementation of a secondary stroke prevention program
- routine and systematic assessment of progress and adjustment of treatment plans
- education for the stroke survivor, the family and the caregiver

- attention to psychological and social issues affecting the stroke survivor, the family and the caregiver
- early discharge planning to ensure effective community re-engagement and early resumption of home, family, recreational and vocational roles whenever possible
- stroke survivor and family education about the possibility of alternate level of care if home is not recommended by the team
- determine nature and extent of rehabilitation services based on stroke severity, functional status and social support

Assessment:

Assessments by appropriately trained clinicians, using standardized and valid screening tools when applicable should include the following:

- physical assessment
- pain assessment (Visual Analogue Scale)
- skin integrity (Braden Scale)
- global functional ability (Functional Independent Measure [FIM])
- mobility, balance and motor function (Clinical Outcomes Variable Scale [COVS], Hemiplegic stages of motor recovery)
- risk for falls (Berg Balance Scale)
- cognitive and perceptual ability (Mini Mental State Exam [MMSE])
- mood (Geriatric Depression Scale)
- communication (Assessment tools specific to communication issues identified by SLP)
- swallowing (Bedside swallowing assessment - SLP)
- continence screening (refer to P&P III-47: Bladder Management Program and Voiding Screening Tool)

Other discipline specific assessment tools may be used as appropriate.

Timelines for Rehabilitation Planning:

- Rehabilitation planning should be initiated in the transition phase of the Stroke Emergency Acute Pathway
- Within 3-7 days of admission to the rehabilitation unit, the team will initiate referral acknowledgment and team assessment and treatment planning will begin based on the intensity requirement of the stroke survivor.
- Weekly assessment by the rehab team should be done to monitor progress, adjust therapy and direct rehabilitation decisions.

Family and Caregiver Involvement:

- Family and caregivers should be involved in decision making and treatment planning throughout the duration of the rehabilitation process
- Rehabilitation team members should be alert to family/caregiver stress associated with impairments and provide support, as indicated
- Family and caregivers should be provided with up to date information on community resources and the rehabilitation team should assist in obtaining other needed services as required

- Psychosocial and support needs should be reviewed regularly by social worker/rehabilitation team to minimize caregiver distress
- The case manager will be the primary team member responsible for facilitating the communication between team members regarding family/caregiver education on:
 - the nature of the stroke
 - stroke rehabilitation management and outcome expectations
 - family and caregivers roles in the process
- The family conference will be coordinated by the case manager
- If indicated a pre discharge assessment/ home visit will be coordinated by the case manager. Weekend passes are also encouraged.

Education:

- Patient and family education will be documented on the multidisciplinary education flow sheet to ensure communication between the multidisciplinary team, prevent duplication and/or conflicting information sharing, and identify the need for reinforcement/continuing education as appropriate.

Rehabilitation Management Specific to Stroke:

The expected length of stay for stroke rehabilitation is generally 4 weeks provided the patient meets the criteria of moderate disabilities, who have the physical endurance to participate in at least 3 hours of therapy per day and do not have severe cognitive impairment.

A length of stay up to 6 weeks may be required for patients with more severe disabilities, who have the physical endurance to participate in < 3 hours of therapy per day and do not have severe cognitive impairment.

Admission day:

- Initiate multidisciplinary team orders
- Reassess advanced directives with patient and family
- Pharmacy consultation to ensure appropriate medications prescribed on transfer

Assessment Phase (Week 1):

Patient outcomes	Optimal feeding method in place Continence/incontinence routine established Patient is participating in self-care and therapy programs
Patient monitoring and assessment	Assess mental status and cognitive and perceptual function Reassess if indicated, swallowing, nutritional risk, communication, risk for falls, pain, mobility, and level of assistance required for safe transfer Screen for signs of depression Screen for drug related issues Multi D team assessments
Activity	Initiate self-care retraining Continence/incontinence management Transfer and mobility therapeutic treatment initiated
Nutrition	Continue appropriate feeding method, food texture and diet

Interventions	Other therapeutic activities initiated Depression addressed if applicable Pain management addressed if applicable
Referrals	Case manager to ensure pre printed orders completed for referrals
Discharge planning	Gather information and discuss initial discharge plans with patient/family
Patient family education	Stroke prognosis, patient/family expectations, rehabilitation process and transfer mobility status

Treatment Phase (Week 2-3)

Patient outcomes	Day/weekend pass – patient and family can manage with or without supports
Patient monitoring and assessment	Determine the need for pre-discharge home visit (CCAC-OT) Determine need for assistive mobility devices <i>Assess caregivers coping ability (burden) using quality of life assessment tool (e.g. care giver strain index) if indicated</i> Assess weekend leave outcomes, the need for home modifications, equipment and a personal alarm system if indicated Self/caregiver medication program
Activity	Participate in treatment plan
Nutrition	Review compliance with and tolerance of feeding method, diet type, and food texture.
Interventions	<i>Review results of caregiver coping ability (burden) assessment and develop plan of care if necessary</i> Evaluate stroke prevention therapy and risk factor modification prn
Referrals	CCAC/Rehabilitation Day Hospital
Discharge planning	Discuss post discharge programs and services Family conference to discuss patients progress, plan discharge date and discharge destination Obtain, review and discuss multidisciplinary care plan on patients goals, confirm discharge plans and discuss alternative plans if indicated Identify the need for home modification Notify Ministry of Transportation as required by CMA/MTO guidelines about driving ability as appropriate. Screen patient for eligibility and refer to CCAC or Rehab Day Hospital if indicated Initiate application forms for CCAC, Day programs and or RDH as indicated Medical follow up plans initiated
Patient family education	Consolidate skills training for the patient and family Discipline specific education as appropriate Provide information on: <ul style="list-style-type: none"> • Alternative transportation (transhelp) • Personal alarm system • Process for obtaining home modification equipment • Wheelchair parking application form

Discharge Phase (Week 4):

Patient outcomes	Patient/family aware of and agree to plans for their out patient phase of care Identified patient goals met.
Patient monitoring and assessment	Determine the need for prevocation assessment.
Investigations	Follow up investigations identified and arranged.
Activity	Participation in functional activities, ADL, etc.
Nutrition	Diet and swallowing recommendations reviewed with patient and family
Interventions	Continue the care plan
Referrals	Family physician or neurologist follow up prn. Single discipline referral as required Rehabilitation Day Hospital referral as required (See referral criteria**)
Discharge planning	Assessment date for RDH Ensure follow up plans are in place to address stroke risk factors and continued treatment of co morbidities/complications.
Patient family education	Review medication prescriptions and instructions with patient/family. Identify resources for grief counseling, personal relationship issues prn. Provide and review information about community resources.

** Rehabilitation Day Hospital Referral Criteria:

- Patients requiring specialized assessment, education and therapeutic treatment by two or more different disciplines
- Patient is assessed to be able to tolerate a course of therapy
- Patient is committed to attend regular therapy sessions
- Patient is able to arrange transportation to their scheduled appointments
- A referral is signed by the physician caring for the patient on the rehabilitation unit

Discharge Day:

The patient has met the discharge criteria outlined in the Patient Family Conference letter and/or alternative plans have been made to facilitate discharge.

Review and address any unresolved concerns with patient and family/caregiver prior to discharge. Ensure written information has been provided to patient and family and confirm they understand all discharge instructions, plans and follow up.

Provide family with contact name and number for CCAC case manager and/or RDH.

Evaluation:

The following outcome measurements will be monitored through the Rehabilitation Steering Committee.

CIHI Rehabilitation Dataset

- LOS
- FIM

COVS

Braden scale

NRC and Picker Satisfaction Data

Approval:

Department of Internal Medicine: June 21, 2005

Department of Family Medicine: June 30, 2005

Rehabilitation Steering Committee: May 12, 2005

CQCC, PPAC, MAC: Sept 2005 (FYI)

Developed by:

Rehab Programme Steering CPG subcommittee:

Leader – Geriatrician/Clinical Supervisor Physiotherapy. Team members – Stroke Rehabilitation Team and Quality Facilitator.

References:

Adapted from the Heart and Stroke Foundation of Ontario 2003 – Best Practice Guidelines for Stroke Care www.stroke-info.com

VA/DoD clinical practice guideline for the management of stroke rehabilitation in the primary setting. www.guideline.gov