## Waterloop Wellington Rehabilitative Care System
### Integrated Care Pathway for STROKE
### Stream of Care
### INPATIENT REHABILITATION

<table>
<thead>
<tr>
<th>Care Setting</th>
<th>Activity</th>
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<tr>
<td></td>
<td>• All patients who require rehabilitation will be referred to a specialized rehab team in a geographically defined unit.</td>
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<td>• Referral to inpatient rehab will be completed in the acute stroke unit on day 3 using AlphaFIM to guide appropriate rehab destination according to the banding model.</td>
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<td>• Admission to inpatient rehab on day 5 (ischemic) and day 7 (hemorrhagic) through CCAC centralized intake process.</td>
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<td>• If day 5 or 7 falls on a weekend preplan admission with CCAC and partner organizations</td>
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<td>• Complete admitting standard Stroke Rehab Admission Order Sets</td>
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<td>• Admission in first 24 - 48 hours (physical assessment, admission profile, mobility screen, medication review &amp; BPMH).</td>
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<td>• Assessment (PT, OT, medicine, nursing, speech, social work, pharmacy, nutrition, recreation therapy, physiatry, psychology) within 48 hrs.</td>
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<td>o Assess patients and develop a comprehensive individualized interdisciplinary rehab plan which reflects severity of stroke and individualized needs of patients.</td>
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<td>o Caregivers should be given the opportunity to participate in therapy if desired</td>
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<td>• Assign primary point of contact for patient. Sign in primary point of contact and program information into patient owned Stroke Care Passport</td>
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<td>• Offer opportunity for patient to participate in linking survivors with survivors program</td>
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<td>• <strong>Predictive discharge letter</strong> given to patient using RPG to guide expected LOS by day 5.</td>
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<td>• Predicted LOS based on Ontario Stroke Network Recommendations:</td>
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<td></td>
<td>o RPG 1100 – 48.9 days</td>
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<td></td>
<td>o RPG 1110 – 41.8 days</td>
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<tr>
<td></td>
<td>o RPG 1120 – 25.8 days</td>
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<tr>
<td></td>
<td>o RPG 1130 – 25.2 days</td>
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<tr>
<td></td>
<td>o RPG 1140 – 14.7 days</td>
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<td>o RPG 1150 – 7.7 days</td>
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If you have any questions please contact Jennifer Breaton
Integrated Stroke Program Director, [jennifer.breaton@grhosp.on.ca](mailto:jennifer.breaton@grhosp.on.ca)  
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• Involve and communicate with patient and family in goal setting.

• Schedule Care conference with patient, family and care team. Care conference to review:
  o Care plan & expected LOS
  o Functional goals and rehab objectives
  o Community resources and discharge planning

• Clinicians should use standardized valid assessment tools to evaluate the patients stroke related impairments.
  • The **FIM Tool** should be used as a standard assessment tool on admission and discharge.
  • Screen on admission for falls risk using a valid and reliable screening tool.
    o If high risk for falls implement individualized fall prevention strategy.
  • Screen for depression using the **Geriatric Depression Scale (GDS).**
    o If screened positive refer to clinician with post stroke depression expertise.
    o **Consider referral to a post stroke depression clinic via OTN**

• Patients with aphasia or aspiration should receive a full clinical assessment by an SLP.

• Patients should be placed on an oral care protocol. If dental issues identified consider a dental/denturist consultation.

• Patients with stroke related visual difficulties referred to optometrist with stroke expertise.

• Screen for cognitive impairments using the **Montreal Cognitive Assessment (MoCA),** when appropriate.
  o If cognitive impairments are identified, arrange additional cognitive or neuropsychological assessments to guide management.
  o **Consider referral to post stroke cognition clinic via OTN**
• Stroke patients should receive through an individualized treatment plan, at least 3 hours of direct task specific therapy per day by the interprofessional stroke team for 5-6 days a week.
  o Measure nature and intensity of rehabilitation (workload measurement systems) to ensure recommended intensity is provided.

• Formal inter professional meeting are conducted once weekly (minimum) to:
  o Identify patient issues
  o Set rehab goals
  o Monitor patient progress
  o Plan discharge support

• Apply the WW Rehab Care Discharge Decision Making Framework to evaluate patients appropriateness to community/outpatient/CCAC services

• Ideally the patient is discharged to either outpatient rehab or community with:
  o Completed WW Transition Checklist
  o Contact person for next stage in care
  o In-face meeting (to communicate over arching goals). Consider OTN to enable this.
  o Appointment times - first visit within 7 days of discharge
  o Transportation needs arranged

• Provide linkages and information for Stroke Recovery Chapters.

• Should a patient require return to acute care in a non emergent nature notify the stroke navigator to assist with the transition

Attachments:
✓ Stroke Care Passport
✓ FIM Tool
✓ Geriatric Depression Screen
✓ Montreal Cognitive Assessment (MoCA)
✓ WW rehab care discharge decision making framework
✓ WW Transition Checklist
✓ Predictive discharge letter

Highlighted items in development (coming soon)