ACUTE PHASE / TRIAGE

All stroke patients identified by Triage early in admission. Enter & track on CART

Stroke Reg / Triage Nurse: Attend FMC stroke unit brief Mon—Fri; Attend RAH for patient review x 3 days per week; Liaise with acute team regarding plan after Rehab assessment

Triage assessment (including case note review) within 48Hrs of admission

Accept receipt of Triage assessments from other Networks

Identify (refer to acute AH processes) — home safety, social issues, barriers to D/C

Pathway — default / 1st consideration to ambulatory (refer to inpatient, home, day rehab criteria)

Rehab options, expected LOS, requirements on D/C discussed with — patient, family, carer

Default — all stroke patients receive a Rehab plan unless end of life or patient declines program

Access to meeting with a Rehab Consultant

Plan formal consults with other teams as needed

Stroke investigations: Carotids, Echo, Holter, MRI, Anticoag mx plan

Handover – transition of clinical information / Triage assessments (includes equipment, Bariatric)

Early referrals prompted (includes DSA, MAC, indigenous services)

Active pull to Rehab

Triage phone review on transfer day to ensure medical stability

REHABILITATION STROKE PATHWAY - CHECKLIST ✔

- 4AZ3—Weighted FIM Motor 13-18 Age >65 LOS TARGET = 32
- 4AZ4—Weighted FIM Motor 13-18 Age <65 LOS TARGET = 53
- 4AA1—Stroke FIM Motor 51-91 Cog 29 LOS TARGET = 12
- 4AA2—Stroke FIM Motor 51-91 Cog 19-28-35 LOS TARGET = 16
- 4AA3—Stroke FIM Motor 51-91 Cog 5-18 LOS TARGET = 23
- 4AA4—Stroke FIM Motor 36-50 Age ≥ 68 LOS TARGET = 25
- 4AA5—Stroke FIM Motor 36-50 Age ≤ 67 LOS TARGET = 31
- 4AA6—Stroke FIM Motor 19-35 Age ≥ 68 LOS TARGET = 38
- 4AA7—Stroke FIM Motor 19-35 Age ≤ 67 LOS TARGET = 53

INPATIENT / HOME REHAB

DAY OF REHAB ADMISSION

Pre arrival handover — a.m. brief. Key worker assigned (within 24 Hrs)

70% Transfer in before 11.30

Build on handover / assessments received. Minimise duplication Assessments include — medical, pharmacist review, nutrition-MNA, pain, self care, chronic disease management

Swallow recommendations documented

Continence assessment – bowel bladder interventions

Falls risk assess / individualised preventative strategies (Multi-D)

Braden / Pressure prevention

Transfer / Mobility assessment Preliminary discussion re goals as part of assessment: achieve safe mobility for discharge

Seen by Consultant within 24 Hrs

Activity / therapy / functional re-training / hydro commenced

New patient screen

I-Pad provided (device set up)

Equipment review and set up

Up to 72 Hrs POST ARRIVAL

FIM Assessment

Establish goals with patient

(Multi-D) - maximize function and ensure safe discharge

* **Stroke Liaison responsibilities**

Care plan / journey document initiated by Key worker. Therapy time table initiated

1st case conference - FIM review, SN Class identified, D/C plan

Social worker — Consider early referral to TCP / DSA. Schedule family meeting

Expected LOS communicated to patient (Consultant) / family (KW) / team

Activity / therapy / functional re-training / hydro / group / self directed

Consider OT home visit

Early flag to ambulatory Rehab and Tele-Rehab / other therapy options, Identify carer training needs

Seen by medical officer within 48 Hrs (Telehealth)

Timetable of visits (daily up to multiple)

PROGRESSION

Daily brief — succinct

>120 mins therapy daily

Structured activity — evenings Consultant review and Case

Conference x2 weekly

6 day a week medical ward round (driving discussed)

Team facilitate carer training

Team provide falls education / exercise program

Other risk factors (e.g. bowel, bladder issues managed

Team facilitate coaching — self management

Regular goal review — key worker

Contact provided—stroke support group

Regular Consultant review as required

7 day interventions

DAY PRIOR D/C

Medications ordered / Pharmacist education

Patient experience questionnaire captured

Arranged — ongoing therapy, support services, follow up appointments, equipment, anticoagulation management, D/C transport

D/C summary completed

End FIM / AROC completed

DAY of D/C

Care plan updated. Acute and Rehabilitation D/C summaries handed to patient

Meds provided

Informed — post D/C contact.

10 am D/C

Stroke Liaison summary sent to GP / other specialists

Stroke Liaison Follow up (consider transition to ambulatory Rehab) Telephone review at 2 weeks post Rehab

Community Services—Day Therapy/ External Therapy/Support providers

DAY REHAB

* STROKE LIAISON

Meets with patient and family

'My stroke Journey' used to guide conversation—covers diagnosis, type of stroke, impairment, Neuroplasticity (DVD), address modifiable risk factors / 2ndry prevention measures

AROC / Lawton's captured

No formal assessment – handover from other rehab services

Transport not a barrier to accessing services

Client centred scheduling

Maximise telehealth

Push coaching model

Continued falls risk factor modification

Return to baseline mobility