



*West GTA Stroke
Network*



Community Stroke Best Practice Guidelines

February 2005



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West GTA Stroke Network



Community Stroke Best Practices - Introduction

Stroke is a leading cause of disability among elderly people and although the majority of survivors will return home, approximately 85% of them will be restricted in some way with activities of daily living. Residual deficits can be physical, cognitive, perceptual or sensory and can affect the survivor and family both emotionally and socially. In addition to individual and family consequences, the economic impact on the health care system is tremendous.

In June 2000, the Ministry of Health and Long Term Care allocated funds to support regional stroke networks which would be responsible for ensuring coordinated stroke services through the continuum of care. This included stroke prevention, emergency and acute care, rehabilitation, transition management and community re-engagement. By implementing the integrated stroke strategy, it was expected that the incidence of stroke mortality and residual disability would decrease across the province and that individuals who suffer a stroke will receive consistent care based on best practices.

In year four of the Coordinated Stroke Strategy, the West GTA Stroke Network conducted a pilot project called "Navigating the Seams" which looked at the transition management of stroke survivors discharged home with community supports. One of the goals of this project was to develop, implement and evaluate best practice guidelines for stroke survivors receiving services through the Community Care Access Centres (CCACs). A project manager was hired, and a Community Best Practices Committee was formed with representatives from the four CCACs in the region, contracted service provider agencies as well as a number of adhoc/advisory committee members.

This group was committed to developing a resource tool that was based on evidence and/or best practice that was user friendly and easily integrated into processes currently being used by the CCAC. The guidelines are intended to facilitate discussion, collaboration, decision making and mutual understanding between case managers and service providers as they develop individual treatment and service plans. Some client/family needs and circumstances may require special accommodation and deviation from the guidelines. These will be addressed on a case by case basis by the health care team.

By implementing the stroke service guidelines, it is anticipated that stroke survivors and their families will have timely, equitable and consistent access to services in the community across the West GTA Region and that CCAC resources will be utilized effectively and efficiently. The service model will be one more step in the transition process which assists stroke survivors and their families to successfully re-engage in their community.



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CCAC Stroke Best Practices Committee

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In addition to this committee, many individuals including rehab service providers, nurses, case managers and educators have reviewed and/or provided feedback and input to these guidelines. Many thanks to everyone for your interest and efforts in making this project a success. These guidelines are work in progress. Any comments or thoughts on how to improve these guidelines would be most welcome.



West GTA Stroke Network



Community Care Access Centre Stroke Best Practices

How to use the Guidelines

The Community Stroke Best Practice Guidelines were developed in collaboration with Community Care Access Centres (Dufferin-Wellington, Etobicoke, Halton and Peel), Rehab and Nursing provider agencies and The West GTA Stroke Network. They serve the following purpose:

- To facilitate case management decision making related to service planning (number of visits and length of stay to achieve goals)
- To provide resource information to service providers regarding best practices in stroke care
- To enhance communication and mutual understanding regarding expectations between service providers and case managers
- To improve access and consistency of services to stroke clients (right person, providing right service at right time)
- To facilitate successful re-engagement of the stroke client into the community

What is included in the guidelines?

The model consists of two components:

1. Priority Admission Process

- Priority Assessment Tool Definitions
- Rehabilitation Priority Examples
- Priority Assessment Tool for In-home Services

2. Service Model

- Service Guidelines
- Factors That May Impact Service Guidelines
- Functional Issue Templates for ADL, caregiver support, cognition and perception, communication, community re-engagement, dysphagia, elimination, family/social support, home environment, instrumental ADL, medication, mobility, mood disorder, nutrition, shoulder pain, skin integrity, swallowing, upper and lower extremity motor recovery, wheelchair/seating system
- Case Management Template

Priority Admission Process

These tools were developed to assist the case manager in prioritizing the service needs for stroke clients. A client's needs are assessed as high, medium or low, based on acuity in the areas of safety/risk, predicted outcome of intervention, coping/adaptation, general health status and client /family education. A client assessed with high needs will receive service within 48 hours of referral, medium within two weeks of referral and low within one month of referral. A Rehab Priority Example sheet is included to more clearly define specific issues for the various rehab services. The Assessment Tool for In-home Service is a check list which is to be completed by the intake case manager to identify which services are required and the level of priority.

Service Model

The service guidelines sheet summarizes all the potential functional issues and service needs that a stroke client may require, the most appropriate service provider, the average number of visits and average number of weeks on service. Also included is a template for each functional issue which provides information specific to service provider assessment, intervention/treatment and discharge planning. The case management template provides a general overview of activities that need to be completed for all stroke clients.

General Principles

1. The client must meet CCAC eligibility criteria in order to receive services.
2. The guidelines provide an average range for number of visits and length of service for each functional issue that a stroke client may experience. It is expected that some clients will require fewer visits or shorter lengths of stay, and some may require more visits and longer lengths of stay. The number of visits and weeks on service are not added if the client presents with more than one functional issue. Included in the package is a list of potential reasons why the service plan may need to be altered.
3. The guidelines are intended to be an adjunct to the RAI-HC (Resident Assessment Instrument for Home Care) which is a comprehensive, standardized instrument for evaluating the domains of function, health social support and service use. The case manager can use the Stroke Best Practice Guidelines in the analysis of the CAPS (Client Assessment Protocols) to develop SMART goals, expected client outcomes, and a service plan with the client/caregiver and service provider.
4. The guidelines are a resource tool for service providers to assist with the assessment and development of intervention strategies and discharge plans for stroke clients. They are not meant to replace professional practice standards.
5. In an effort to utilize resources effectively and efficiently, it is critical for case managers and service providers to consider the appropriateness of the timing of a referral for service.

Examples:

- A client returning home from the hospital may not be ready to explore community resources or programs for several months.
- A mood disorder may not be evident upon return home, but may develop at a later date.
- Caregiver burnout or family issues related to caring for the stroke client may develop over time.

**COMMUNITY CARE ACCESS CENTRE - STROKE BEST PRACTICES
PRIORITY ASSESSMENT TOOL DEFINITIONS**

| | HIGH (1) within 48 hours of referral | MEDIUM (2) within 2 weeks of referral | LOW (3) within 1 month of referral |
|--------------------------------|--|--|--|
| Safety/Risk | <ul style="list-style-type: none"> > unsafe/high risk situations for falls or injury > if treatment not received risk of hospitalization > urgent equipment needs | <ul style="list-style-type: none"> > potential for falls or unsafe situations > moderate need for home supports/equipment | <ul style="list-style-type: none"> > equipment/home supports adequate - may need review/reassessment |
| Predicted Outcome | <ul style="list-style-type: none"> > early intervention critical to recovery process - initiation of service will make critical difference towards positive outcomes | <ul style="list-style-type: none"> > early intervention advantageous in recovery process - initiation of service will make significant difference towards positive outcome | <ul style="list-style-type: none"> > ongoing intervention needed in recovery process - initiation of service will make some difference towards positive outcome |
| Coping/Adaptations | <ul style="list-style-type: none"> > absence of caregiver/client cannot manage alone > psychosocial crisis/inadequate coping skills > client has no ability/skills to adjust to new situation/condition > client unable to communicate or express needs/emotions | <ul style="list-style-type: none"> > limited caregiver support/caregiver stress > client coping poorly > client has limited ability/skills to adjust new situation/condition > client has limited ability to communicate or express needs/emotions | <ul style="list-style-type: none"> > caregiver available and managing adequately > client has adequate coping skills > client has adequate ability/skills to adjust to new situation/condition > client is able to communicate or express needs adequately |
| Health Status | <ul style="list-style-type: none"> > temporary unstable medical condition > rapid physical or cognitive deterioration | <ul style="list-style-type: none"> > recent change in health status - new problems/new diagnosis > moderate need to stabilize medical condition | <ul style="list-style-type: none"> > stable health status > gradual progressive medical physical or functional changes |
| Client/Family Education | <ul style="list-style-type: none"> > urgent need for education of client or caregiver/PSW > no knowledge/education regarding disease process/condition | <ul style="list-style-type: none"> > moderate need for education of client or caregiver/PSW > limited knowledge/education regarding disease process/condition | <ul style="list-style-type: none"> > minimal need for education of client or caregiver/PSW > re-inforcement or enhancement of previous education |

**COMMUNITY CARE ACCESS CENTRE
STROKE BEST PRACTICES
REHABILITATION PRIORITY REFERRAL EXAMPLES**

| DISCIPLINE | HIGH | MEDIUM | LOW |
|-----------------------------|---|--|---|
| OCCUPATIONAL THERAPY | <ul style="list-style-type: none"> • high risk or unsafe with functional activities • i.e. toileting, feeding • urgent equipment needs i.e. for bathroom, transfers • booking of pre-discharge assessment while in hospital • urgent need for teaching of caregiver/PSW related to hooyer transfers | <ul style="list-style-type: none"> • potential for increased motor recovery and functional status of U/E high (1-3 months post stroke) • decrease in functional status, safety issues related to cognitive/perceptual/ sensorimotor deficits (poor self care, transfers, household management) • teaching/training of caregiver in hooyer transfers, exercise program • seating issues related to swallowing/feeding • some risk issues related to inability of caregiver to manage • personal/functional needs or activities • equipment required to facilitate independence and safety with functional activities | <ul style="list-style-type: none"> • assessment/recommendations for non urgent situations related to: • -physical environment, home access <ul style="list-style-type: none"> - wheelchair and seating issues - community living skills (banking, shopping) • -community linking (access to services/resources) • -energy conservation, work simplification • -leisure/socialization activities • -domestic activities (cooking, cleaning, laundry) • -use of public transit • -driving ability <ul style="list-style-type: none"> - return to work, modified work program |
| PHYSIOTHERAPY | <ul style="list-style-type: none"> • high risk for falls related to poor balance, lack of appropriate equipment, no caregiver, poor judgement • early onset of stroke – (less than 1 month) - therapy essential to facilitate U/E, L/E motor recovery • severe shoulder pain • acute respiratory problem requiring chest physiotherapy – i.e. aspiration pneumonia • urgent need for teaching of caregiver/PSW related to transfers, mobility or positioning | <ul style="list-style-type: none"> • client requires appropriate mobility aids to facilitate independence • potential for increased motor recovery high (1-3 months post onset of stroke) • moderate need for teaching of caregiver/PSW related to transfers/ mobility • poor exercise tolerance or fatigue interferes with function • pain/swelling present in shoulder/hand • unable to manage stairs safely • at risk for injuring arm/hand due to neglect or sensory changes • intervention required to improve posture/balance/movement disorder | <ul style="list-style-type: none"> • ongoing therapy required to improve functional status/independence or deficits in the following areas • -muscle tone/strength • -coordination • -posture and balance • -joint problems (contractures) • -circulatory problems • -mobility/transfers • chronic pain • potential for motor recovery continues (post 3 months onset) • home exercise program requires review/modification |

| DISCIPLINE | HIGH | MEDIUM | LOW |
|----------------------------------|---|---|---|
| DIETETICS | <ul style="list-style-type: none"> high risk for aspiration, client requires food of modified consistency alternative means of feeding or hydration are required teaching required re: tube feeding severe nausea or vomiting present | <ul style="list-style-type: none"> moderate risk for aspiration-client requires food of modified consistency poor nutritional diet/intake, client is losing weight limited or no teaching re: nutrition/diet | <ul style="list-style-type: none"> reinforced teaching of therapeutic diet client is obese, weight reduction necessary management of medical co-morbidities i.e. diabetes, renal disease |
| SOCIAL WORK | <ul style="list-style-type: none"> rapid breakdown in basic living needs i.e. housing, food r/t new situation high risk for injury or violence to client or caregiver, unable to cope/adjust to new situation or condition | <ul style="list-style-type: none"> signs and symptoms of depression, anxiety or mood disorder present client/caregiver ability to cope/manage is limited, psychosocial support needed assistance with financial resources required to maintain status in community | <ul style="list-style-type: none"> referral/linkage to community resources/support groups transitional planning for ongoing care requirements assistance with coping strategies impact of stroke affects family dynamics emotional support for client/caregiver required to maintain status in the community |
| SPEECH LANGUAGE PATHOLOGY | <ul style="list-style-type: none"> acute onset of dysphagia or acute change in swallow function NPO status frequent and/or consistent coughing on food/drink signs/symptoms of aspiration present no functional means of communication, client lives alone | <ul style="list-style-type: none"> inability to safely manage recommended diet texture but still able to eat/drink orally weaning from enteral feeds to oral intake communication deficits with limited caregiver support caregiver strategies (home programming) re: effective communication cognitive-communication impairment present | <ul style="list-style-type: none"> potential for improvement in communication skills or strategies continues (post 3 months onset) augmentative/alternative communication needs |

INDICATION FOR NURSING REFERRAL

DEFINITIONS

| | | |
|---|--------|--|
| <ul style="list-style-type: none"> management and/ or education related to problems/issues with: <ul style="list-style-type: none"> bowel and bladder function medical co-morbidities, risk factors i.e. diabetes, cholesterol, hypertension medication skin integrity, pressure sores enteral feeds | High | <ul style="list-style-type: none"> within 48 hours of referral |
| | Medium | <ul style="list-style-type: none"> within two weeks of referral |
| | Low | <ul style="list-style-type: none"> within one month of referral |

**COMMUNITY CARE
ACCESS CENTRE**

Client Name:

HCN:

DOB:

**Priority Assessment Tool for In-home Services
Stroke Best Practices**

| Discipline | Safety/ Risk | Predicted Outcome | Coping/ Adaptation | Health Status | Client/Family Education |
|--|-----------------|----------------------|-----------------------|------------------|----------------------------|
| <u>Nursing</u> *Elimination *Meds/risk management *Skin Integrity | | | | | |
| <u>OT</u> *ADL *Caregiver Support/Education *Cognition/Perception *Community Re-engagement *Home Environment *Instrumental ADL *Wheelchair/seating | | | | | |
| <u>PT</u> *Mobility/transfers *Shoulder pain *U/E, L/E motor recovery | | | | | |
| <u>RD</u> *Dysphagia *Nutrition | | | | | |
| <u>SLP</u> *Communication *Feeding/Swallowing | | | | | |
| <u>SW</u> *Family/Social support *Mood Disorder | | | | | |

Priority Rating for Admission

| | High | Medium | Low |
|----------------|------|--------|-----|
| Nursing | 1 | 2 | 3 |
| OT | 1 | 2 | 3 |
| PT | 1 | 2 | 3 |
| RD | 1 | 2 | 3 |
| SLP | 1 | 2 | 3 |
| SW | 1 | 2 | 3 |

Completed by:

Date:

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICES SERVICE GUIDELINES

The following list identifies areas of deficit or dysfunction that a stroke survivor may experience and potential reason for referral to a Community Care Access Centre. The model is intended to be used as a guideline for service provision based on identified goals. Variances are expected based on complicating factors and client/family situations.

| Functional Issues | Primary Discipline Involved | Average # of Visits | # of Weeks on Service |
|----------------------------------|-----------------------------|-----------------------------|------------------------|
| ADL (Activities of Daily Living) | OT | 4-6 | 4-6 |
| Caregiver Support and Education | OT | 6-8 | 8-12 |
| Cognition/Perception | OT | 6-8 | 6-8 |
| Communication | SLP | Mild 2-12 Moderate 12-28 | 2-12 Up to 6 Months |
| Community re-engagement | OT | 2-4 | 4-8 |
| Dysphagia (nutrition) | RD | 6-10 | 8-12 |
| Elimination | Nursing | 4-6 | 6-8 |
| Family/social support | SW | 1-8 | 1-12 |
| Home environment | OT | 1-8 | 2-16 |
| Instrumental ADL | OT | 4-6 | 6-12 |
| Medication | Nursing | 4-6 | 4-6 |
| Mobility | PT | 6-8 | 4-10 |
| Mood Disorder | SW | 2-8 | 2-12 |
| Nutrition – specialized diets | RD | 6-10 | 8-12 |
| Shoulder pain | PT | 4-6 | 1-4 |
| Skin Integrity | Nursing | 10-12 | 6-12 |
| Swallowing | SLP | 1-12 | 1-12 |
| U/E, L/E Motor Recovery | PT | 6-10 | 8-12 |
| Wheelchair, Seating System | OT | 4-6 | 4-16 |

The health care team works in partnership with the family physician who is responsible for the ongoing medical management and secondary stroke prevention of the client.

*** Please see individual functional issue templates for alternative disciplines should the primary discipline not be available in a timely manner.*

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FACTORS THAT MAY IMPACT THE RECOMMENDED SERVICE GUIDELINES
(INCREASE OR DECREASE IN VISITS OR WEEKS ON SERVICE)

- ✓ Chronicity, acuity, or severity of condition
- ✓ Multiple diagnoses/conditions, diabetes, osteoporosis, dementia etc.
- ✓ Lack of history, medical information
- ✓ Hospital admission/on/hold/crisis
- ✓ Limited tolerance/activity level
- ✓ Impaired cognition – capacity to learn, follow or adhere to treatment plan
- ✓ Communication disorders (aphasia)
- ✓ Inappropriate behavior prevents active participation in treatment plan
- ✓ Caregiver stress/availability/support/consistency
- ✓ Client and/or family needs/wishes/motivation/cooperation
- ✓ Cultural/language factors
- ✓ Availability of community resources
- ✓ Environmental barriers – housing
- ✓ Funding factors – equipment/transportation
- ✓ Delays in acceptance to community programs
- ✓ Client does not make progress as initially anticipated
- ✓ Sensory deprivation – vision/hearing
- ✓ Availability of informal supports
- ✓ Complexity of care needs
- ✓ Level of family functioning
- ✓ Severity and nature of mood disorder (depression)
- ✓ Availability of effective medical treatment
- ✓ Client's emotional strength/level of competence
- ✓ Family ability to deal with capacity issues
- ✓ Safety-risk issues
- ✓ Nature of relationship of client and support network
- ✓ Family/caregiver ability to access resources independently
- ✓ Waiting time for test/evaluation regarding swallowing
- ✓ Coordinating with other disciplines/health care team

(list is not all inclusive)

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICES CASE MANAGEMENT GUIDELINES

| Activities | Expected Outcomes |
|---|--|
| Initial Assessment | |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Complete Initial Assessment following CCAC assessment procedures • Schedule initial visit with client/family as appropriate • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document all communication with referral source, family • Identify problem areas and concerns via use of RAI, PCS, Functional assessments etc. • Identify need for disciplines/services • Review service provider assessment reports | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client will understand and consent to needed intervention • Roles of the case manager, service provider, client, caregiver, will be articulated and understood • A goal oriented, measurable service plan will be developed in conjunction with the service provider, client and caregiver that meets client's identified needs |
| Intervention | |
| <ul style="list-style-type: none"> • Connect client to alternative resources directly where appropriate • Monitor progress of service plan • Approve/order appropriate equipment/supplies • Re-assess and update service plan goals on an ongoing basis • Monitor service utilization • Liaise with service providers for updates • Communicate all relevant information/changes to providers involved in care of client/family • Perform RAI,PCS re-assessments as per MOH schedule • Establish timelines for recommended visits or interventions • Coordinate family conference/ service provider meeting as required | <ul style="list-style-type: none"> • Client/caregiver is receiving necessary services related to identified needs • Services are client specific • Client/family understand the potential risk for medical complications due to condition/diagnosis • Intervention improves the quality of life for the client/caregiver/family |
| Discharge/Follow up | |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client/family regarding reason for discharge and follow-up plan or how to initiate re-assessment • Determine ongoing needs for further services • Refer or recommend alternative community program/resources as appropriate • Communicate plans of discharge to all relevant health care providers • Complete discharge documentation | <ul style="list-style-type: none"> • Client will have achieved the identified goals • All relevant parties are informed of discharge plans • Client/caregiver are satisfied with service and outcomes • Client/caregiver are informed and /or linked to alternative community resources where appropriate • Client/ family have contact names and numbers should further service be required |

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|------------------------------------|---|
| Functional Issue: Dysphagia | Primary Discipline: Dietetics Other Discipline Involvement: SLP, Nursing |
|------------------------------------|---|

Service Need: Client requires specialized diet for dysphagia (swallowing difficulty)

Goal: To decrease risk of aspiration and safely manage altered nutritional status

| Initial Assessment | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Dietetic assessment - Include the following: <ul style="list-style-type: none"> ◦ dietetic history ◦ current nutritional status ◦ anthropometric data, lab data ◦ cultural and religious factors that impact nutritional status ◦ oral care and dental hygiene ◦ psychosocial issues ◦ food allergies ◦ medications • Assess for alternative feeding methods such as tube feeding or TPN • Assess need for transition between oral and non oral feeding • Review medications, form (liquid or solid) and potential for food/drug interactions • Complete outcome measurement tool • Review SLP assessment for pertinent information related to swallowing status • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate potential timeline for recommended management or intervention • Obtain and document client's consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Client's nutritional requirements will be determined – macronutrients, fluid, energy, loss in lean body mass total body fat stores, skin integrity • Identification of micronutrient deficiency • Determination of behavioural modification required to meet nutrient needs • Client/caregiver demonstrates knowledge and ability to manage tube feeding or TPN • Maximize oral feeding (versus non oral) when appropriate • Determination of need for strategies re: form of medications or timing/scheduling • Identify signs of swallowing difficulty • Reduced risk of aspiration • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager's service plan |

| Intervention | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Assess learning capability and willingness to change • Educate client/caregiver regarding special diet, risk/safety issues and proper positioning related to swallowing • Adjust strategies to cope with symptoms that affect dietary intake • Monitor biochemical and anthropometric data • Consider need for enteral feeding if nutritional needs not met orally • In consultation with SLP, establish food and fluid consistency modifications • Pursue funding options for supplies and equipment – ADP , ODB • Monitor client’s respiratory status • Monitor client’s tolerance of recommended diet • Observe for signs and symptoms of dysphagia: pocketing of food, difficulty managing oral secretions, wet voice, choking • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client/caregiver will have knowledge of how to meet nutritional requirements with a balanced nutritional care plan, recipes and samples provided • Specific cultural and dietary needs are met • Client/caregiver will have knowledge of basic feeding and swallowing strategies • Client/caregiver will be independent in meal planning and food preparation • Client is able to maintain an adequate nutritional intake as per recommended diet • Client/family/SDM will understand the potential safety risks related to condition • Potential risk of aspiration is minimized • Intervention improves the quality of life for the client/caregiver/family |

| Discharge/Follow-up | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Determine ongoing needs for dietary intervention • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Dietetic discharge assessment /report and outcome measurement tool • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Decreased risk of aspiration • Safe management of altered nutritional status • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|---|---|
| <ul style="list-style-type: none"> • Average Number of Visits 6-10 | <ul style="list-style-type: none"> • Number of Weeks on Service 8-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|--|--|
| Functional Issue: Nutrition – specialized diet for malnutrition, dehydration, wound healing | Primary Discipline: Dietetics Other Discipline Involvement: Nursing |
|--|--|

Service Need: Client requires specialized diet for malnutrition, dehydration and wound healing

Goal: To decrease risk of dehydration and skin breakdown and optimize nutritional status utilizing a specialized diet

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Dietetic assessment - Include the following: <ul style="list-style-type: none"> ◦ dietary history ◦ current nutritional status ◦ anthropometric data, lab data ◦ cultural and religious factors that impact nutritional status ◦ oral care and dental hygiene ◦ psychosocial issues ◦ food allergies ◦ medications • Assess for alternative feeding methods such as tube feeding or TPN • Assess need for transition between oral and non oral feeding • Assess learning capabilities and willingness to change • Review medications, form (liquid or solid) and potential for food/drug interactions • Using Braden Scale for wounds – assess need for supplements to increase intake of kcals, protein, Vitamin C and zinc to promote skin integrity and facilitate wound healing • Complete outcome measurement tool • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate potential timeline for recommended management or intervention • Obtain and document client’s consent to proceed with intervention | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Client’s nutritional requirements will be determined – macronutrients, fluid, energy, loss in lean body mass total body fat stores, skin integrity • Identification of micronutrient deficiency • Determination of stage of wound • Determination of behavioural modification required to meet nutrient needs • Client/caregiver understand treatment strategy to promote wound healing • Client/caregiver demonstrates knowledge of and ability to manage tube feeding or TPN • Maximize oral feeding (versus non oral) when appropriate • Determination of need for strategies re: form of medications or timing/scheduling • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan • Tolerance of medications in relation to food |

| | |
|---|--|
| <ul style="list-style-type: none"> Communicate assessment findings to case manager | |
|---|--|

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Educate client/caregiver regarding special diet, risk/safety factors Adjust strategies to cope with symptoms that affect dietary intake e.g. texture modification Monitor biochemical and anthropometric data Monitor for signs of thrush Consider need for enteral feeding if nutritional needs not met orally Pursue funding options for supplies and equipment – ADP , ODB Monitor client's respiratory status Evaluate outcomes Re-assess and update treatment goals on an ongoing basis Liaise with other health professionals as required Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> Client/caregiver is receiving optimal services including education/information related to identified needs Services are client specific Client/caregiver will have knowledge of how to meet nutritional requirements with a balanced nutritional care plan, recipes and samples provided Specific cultural and dietary needs are met Client/caregiver will be independent in meal planning and food preparation Client/family/SDM will understand the potential safety risks related to condition Intervention improves the quality of life for the client/caregiver/family |

| Discharge/Follow-up | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Evaluate goal attainment Determine ongoing needs for dietary intervention Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment Communicate discharge plans to case manager and any relevant disciplines Complete Dietetic discharge assessment /report and outcome measurement tool Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> Decreased risk of dehydration and skin breakdown Optimal nutritional status and compliance with specialized diet Client/caregiver is informed and/or linked to alternative community resources where appropriate Client/caregiver is satisfied with service and outcomes Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|---|---|
| <ul style="list-style-type: none"> Average Number of Visits 6-10 | <ul style="list-style-type: none"> Number of Weeks on Service 8-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|--------------------------------------|---|
| FUNCTIONAL ISSUE: Elimination | Primary Discipline: Nursing Other Discipline Involvement: RD, OT |
|--------------------------------------|---|

Service Need: Proper and adequate elimination

Goal: Return to normal bowel and bladder function

| Initial Assessment | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Nursing assessment and/or clinical reports. Include assessment of : <ul style="list-style-type: none"> - history of bowel and bladder function - current bowel and bladder function - current medications - activity level • Identify problem areas and concerns • Develop SMART goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management and teaching • Obtain and document client’s consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Educate client/caregiver regarding the impact of the following factors on elimination <ul style="list-style-type: none"> - diet and hydration - medication - value of regular scheduled toileting - available equipment and supplies • Demonstrate how to measure and record intake and output • Consult with MD for laxative and /or enemas as needed and teach proper use • Initiate and teach proper bowel routine • Monitor and educate re: risk factors and or | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client/caregiver will gain knowledge and experience in bowel/bladder management • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential safety and medical risks related to condition |

| | |
|--|--|
| <p>secondary conditions that can develop</p> <ul style="list-style-type: none"> • Educate client/caregiver as to when to access MD • Teach catheter care if catheter being used • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | |
|--|--|

| Discharge/Follow-up | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete nursing discharge assessment /report • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have achieved the identified goals • Client /caregiver will be independent with management of bowel and bladder • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|--|
| <ul style="list-style-type: none"> • Average Number of Visits 4-6 | <ul style="list-style-type: none"> • Number of Weeks on Service 6-8 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

1-Feb-06

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|-------------------------------------|---|
| Functional Issue: Medication | Primary Discipline: Nursing Other Discipline Involvement |
|-------------------------------------|---|

Service Need: **Safe use of medication**

Goal: **Client/caregiver will be independent with managing medications**

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Nursing assessment and/or clinical reports. Include assessment of <ul style="list-style-type: none"> ◦ history of past medications ◦ current medications used • Identify problem areas and concerns • Identify need for other disciplines /services • Notify physician as appropriate regarding change in health status or additional presenting symptoms • Develop SMART goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management and teaching • Obtain and document client’s consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Nurse will have baseline of client’s knowledge regarding medication management • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Provide education to client/caregiver/SDM re: <ul style="list-style-type: none"> ◦ purpose of medication ◦ proper administration of meds ◦ side effects ◦ interactions with other drugs and/or foods ◦ when to contact physician • Observe for effectiveness of medication using established guidelines | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client/caregiver will understand the purpose of medications and how to administer them properly • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential |

| | |
|--|--|
| <ul style="list-style-type: none"> Evaluate outcomes Re-assess and update treatment goals on an ongoing basis Liase with other health professionals as required Begin discussion with client/caregiver regarding discharge | safety and medical risks related to condition/diagnosis and proper use of meds |
|--|--|

| Discharge/Follow-up | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Evaluate goal attainment Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment Communicate discharge plans to case manager and any relevant disciplines Complete nursing discharge assessment /report Determine ongoing needs for further service/continuity of care Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> Client will have achieved the identified goals Client /caregiver will be independent with managing medications Client/caregiver is informed and/or linked to alternative community resources where appropriate Client/caregiver is satisfied with service and outcomes Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|--|
| <ul style="list-style-type: none"> Average Number of Visits 4-6 | <ul style="list-style-type: none"> Number of Weeks on Service 4-6 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|---|---|
| Functional Issue: Skin Integrity | Primary Discipline: Nursing Other Discipline Involvement: RD |
|---|---|

Service Need: Knowledge to maintain healthy skin

Goal: Client/caregiver will be independent with managing skin disorder

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Nursing assessment and/or clinical reports. Include assessment of : <ul style="list-style-type: none"> - history of skin issues - current skin integrity - problem areas • Review and revise current risk factors using the Braden Scale • Develop SMART goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management and teaching • Obtain and document client’s consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Client’s skin baseline level will be established • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Educate client/caregiver regarding: <ul style="list-style-type: none"> - risk factors that affect skin integrity according to Braden Scale - warning signs of skin breakdown • Obtain MD orders and order supplies • Set up routine of care for healthy skin • Educate client/caregiver as to when to access MD • Monitor diet for protein intake • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client/caregiver will gain knowledge and experience in caring for impaired skin • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential safety and medical risks related to condition |

| | |
|--|--|
| <ul style="list-style-type: none"> Begin discussion with client/caregiver regarding discharge | |
|--|--|

| Discharge/Follow-up | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Evaluate goal attainment Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment Communicate discharge plans to case manager and any relevant disciplines Complete nursing discharge assessment /report Determine ongoing needs for further service/continuity of care Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> Client will have achieved the identified goals Client /caregiver will be independent with managing skin disorder Client/caregiver is informed and/or linked to alternative community resources where appropriate Client/caregiver is satisfied with service and outcomes Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> Average Number of Visits 10-12 | <ul style="list-style-type: none"> Number of Weeks on Service 6-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|---|---|
| Functional Issue: Activities of Daily Living (ADL) | Primary Discipline: OT Other Discipline Involvement: PT, Nursing |
|---|---|

Service Need: **Increase independence with ADL**

Goal: **Client will achieve maximum independence in ADL with or without support(s)**

| Initial Assessment | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Occupational Therapy assessment and/or clinical reports –include a focused ADL assessment • Complete outcome measurement tool • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate potential timeline for recommended management or intervention • Obtain and document client’s consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred* goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Client’s current ADL status will be determined • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Identify adapted procedures/methods to perform ADLs • Identify equipment and/or resources (personal support services or caregiver support) if required • Order equipment for trial or identify where recommended equipment can be purchased • Teach adapted methods and /or use of equipment • Train caregivers if used as support • Evaluate trialed equipment for safety, usefulness and affordability • Facilitate purchase of equipment or funding application as required | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client will possess the necessary equipment or know how to access equipment in the future • Client will use the equipment safely • Client will perform ADLs utilizing adapted procedures and methods • Client will achieve his/her maximum level of independence • The appropriate supports will be in place • Caregivers are able to assist or facilitate ADLs safely with the client |

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|---|--|
| <ul style="list-style-type: none"> • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential safety risks related to condition/situation |
|---|--|

Discharge/Follow-up

| Activities | Expected Outcomes |
|--|---|
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Occupational Therapy discharge assessment /report and outcome measurement tool • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have achieved his/her ADL goals • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

Service Guidelines

| | |
|--|--|
| <ul style="list-style-type: none"> • Average Number of Visits 4-6 | <ul style="list-style-type: none"> • Number of Weeks on Service 4-6 |
|--|--|

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|--|---|
| Functional Issue: Caregiver Support and Education | Primary Discipline: OT Other Discipline Involvement: Social Work |
|--|---|

Service Need: To teach caregiver coping skills

Goal: Caregiver will report feeling less stressed and supported

| Initial Assessment | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Occupational Therapy assessment including information obtained from the caregiver • Complete Caregiver Burden Scale with caregiver • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate potential timeline for recommended management or intervention • Obtain and document client's consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings from the Caregiver Burden Scale will facilitate the development of client/caregiver centred goals • Client/SDM/caregiver will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • A service plan will be developed in conjunction with the service provider, case manager, client and caregiver |

| Intervention | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Identify strategies to address caregiver's specific concerns and issues • Educate caregiver about stroke symptoms and behaviours • Identify equipment and/or resources (personal support services or caregiver support) if required • Order equipment for trial or identify where recommended equipment can be purchased • Facilitate purchase of equipment or funding application as required • Train caregiver on proper techniques for ADL/Mobility activities for which they provide support • Link caregiver/client to appropriate community supports | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific and meet best practices • Client/caregiver will possess the necessary equipment or know how to access equipment in the future • Caregiver/client will use the equipment safely • Caregiver will incorporate training into daily care of client • The appropriate supports will be in place • Intervention improves the quality of life for the client/caregiver/family |

| | |
|--|--|
| <ul style="list-style-type: none"> • Assist with respite and/or placement as appropriate • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | |
|--|--|

| Discharge/Follow-up | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Complete discharge outcome measure • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Occupational Therapy discharge report • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Caregiver reports coping better and demonstrates a reduced score on the Caregiver Burden Scale • Caregiver is knowledgeable about stroke recovery • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> • Average Number of Visits 6-8 | <ul style="list-style-type: none"> • Number of Weeks on Service 8-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|--|--|
| Functional Issue: Cognition, perception | Primary Discipline: OT Other Discipline Involvement: SLP, Nursing, SW |
|--|--|

Service Need: Improve independence with activities affected by cognition and/or perception Difficulties

Goal: Client will learn and use cognitive and/or perceptual strategies to improve Independence and proficiency in tasks

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Review medical history and information as appropriate Schedule initial visit with client/family/SDM Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) Complete/document Occupational Therapy assessment and/or clinical reports –include a focused cognitive, perceptual and /or behavioral assessment Complete outcome measurement tools Identify problem areas and concerns Identify need for other disciplines /services Develop SMART goals and treatment plan Evaluate potential timeline for recommended management or intervention Obtain and document client’s consent to proceed with intervention Communicate assessment findings to case manager | <ul style="list-style-type: none"> Assessment findings will facilitate the development of client/caregiver centred goals Client /SDM will understand and consent to needed intervention Roles of the service provider, client, caregiver, SDM will be articulated and understood A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Provide education to client/caregiver regarding cognitive limitations, strategies, disease process Identify adapted procedures/methods to engage in or improve performance of tasks (tasks are based on client’s goals) Identify aids/equipment and/or resources (job coach, community support worker , EA, personal care services or caregiver support) if required Order equipment for trial or identify where recommended equipment can be purchased Teach adapted methods and /or use of | <ul style="list-style-type: none"> Client/caregiver is receiving optimal services including education/information related to identified needs Services are client specific Client/caregiver/family will understand the impact of cognitive deficits on function Client will use strategies taught to perform tasks with or without support Client will possess the appropriate aids or equipment or know how to access equipment in the future Client will achieve his/her maximum level of independence |

| | |
|---|---|
| <p>equipment</p> <ul style="list-style-type: none"> • Train caregivers on how to cue client to use strategies • Evaluate trialed equipment for safety, usefulness and affordability • Facilitate purchase of equipment or funding application as required • Link client/caregiver to support services and community resources (groups, other programs) • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • The appropriate supports will be in place • Client will be linked to community support services and programs • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential safety risks related to condition/situation |
|---|---|

| Discharge/Follow-up | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Occupational Therapy discharge assessment /report and outcome measurement tool • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have achieved his/her personal goals • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> • Average Number of Visits 6-8 | <ul style="list-style-type: none"> • Number of Weeks on Service 8-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|--|--|
| Functional Issue: Community Re-engagement | Primary Discipline: OT Other Discipline Involvement: SW |
|--|--|

Service Need: Facilitate re-engagement of the client in their community

Goal: Client will be engaged in meaningful community activities

| Initial Assessment | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Review medical history and information as appropriate Schedule initial visit with client/family/SDM Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) Complete/document Occupational Therapy assessment and/or clinical reports. Include assessment of client’s ability to access and participate in his/her community Complete outcome measurement tool Identify problem areas and concerns Identify need for other disciplines /services Develop SMART goals and treatment plan Evaluate potential timeline for recommended management or intervention Obtain and document client’s consent to proceed with intervention Communicate assessment findings to case manager | <ul style="list-style-type: none"> Assessment findings will facilitate the development of client/caregiver centred goals Client /SDM will understand and consent to needed intervention Roles of the service provider, client, caregiver, SDM will be articulated and understood A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Implement treatment plan Provide education to client/caregiver/SDM on community supports, strategies and barriers to community integration Identify equipment and/or resources (disability transportation, support groups in the community) if required Order equipment for trial, when appropriate Accompany client while teaching adapted methods in the community Teach adapted methods for activity completion and/or use of equipment while performing task in the community Educate, train the client and primary caregivers regarding safety issues, risk factors and intervention strategies Facilitate purchase of equipment or funding | <ul style="list-style-type: none"> Client/caregiver is receiving optimal services including education/information related to identified needs Services are client specific Client will possess the necessary equipment or know how to access equipment in the future Intervention improves the quality of life for the client/caregiver/family Client/family/SDM will understand the potential safety risks related to condition/situation |

| | |
|---|--|
| <ul style="list-style-type: none"> application as required Evaluate outcomes Re-assess and update treatment goals on an ongoing basis Liase with other health professionals as required Begin discussion with client/caregiver regarding discharge | |
|---|--|

| Discharge/Follow-up | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Evaluate goal attainment Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment Communicate discharge plans to case manager and any relevant disciplines Complete Occupational Therapy discharge assessment/report and outcome measurement tool Determine ongoing needs for further service/continuity of care Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> Client will have achieved the identified goals Client participates in meaningful community activities with or without supports Client/caregiver is informed and/or linked to alternative community resources where appropriate Client/caregiver is satisfied with service and outcomes Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|------------------------------|---------------------------------|
| Average Number of Visits 2-5 | Number of Weeks on Service 4-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|---|---|
| Functional Issue: Home Environment | Primary Discipline: OT Other Discipline Involvement: PT, Nursing |
|---|---|

Service Need: Evaluation and recommendations for a safe home environment

Goal: Client will be safe within his/her home environment

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Review medical history and information as appropriate Schedule initial visit with client/family/SDM Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) Complete/document Occupational Therapy assessment and/or clinical reports. Include a home safety assessment (e.g. The Safer Home) Complete outcome measurement tool Identify problem areas and concerns Identify need for other disciplines /services Develop SMART goals and treatment plan Evaluate potential timeline for recommended management or intervention Obtain and document client’s consent to proceed with intervention Communicate assessment findings to case manager | <ul style="list-style-type: none"> Assessment findings will facilitate the development of client/caregiver centred goals Client /SDM will understand and consent to needed intervention Roles of the service provider, client, caregiver, SDM will be articulated and understood A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Identify risk behaviours and safety concerns and educate client and family about home safety Make recommendations to reduce risk (equipment services, behavioural changes, environmental modifications) Identify equipment and/or resources (personal support services or caregiver support) if required Order equipment for trial or identify where recommended equipment can be purchased Teach adapted methods and /or use of equipment Train caregivers if used as support Evaluate trialed equipment for safety, usefulness and affordability | <ul style="list-style-type: none"> Client/caregiver is receiving optimal services including education/information related to identified needs Services are client specific Client will possess the necessary equipment or know how to access equipment in the future Client will use the equipment safely Client will function safely within his/her environment Home modifications will be in place or funding applications submitted Services and supports will be in place where required Client/caregiver will be knowledgeable about alternative housing options |

| | |
|---|--|
| <ul style="list-style-type: none"> Facilitate purchase of equipment or funding application as required Educate client/caregiver about alternative housing options if appropriate Evaluate outcomes Re-assess and update treatment goals on an ongoing basis Liaise with other health professionals as required Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> Intervention improves the quality of life for the client/caregiver/family Client/family/SDM will understand the potential safety risks related to condition/situation |
|---|--|

| Discharge/Follow-up | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Evaluate goal attainment Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment Communicate discharge plans to case manager and any relevant disciplines Complete Occupational Therapy discharge assessment/report and outcome measurement tool Determine ongoing needs for further service/continuity of care Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> Client will have achieved the identified goals Client will reside safely within his/her home or principle residence Client/caregiver is informed and/or linked to alternative community resources where appropriate Client/caregiver is satisfied with service and outcomes Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> Average Number of Visits 1-8 | <ul style="list-style-type: none"> Number of Weeks on Service 2-16 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|---|--|
| Functional Issue: Instrumental ADL | Primary Discipline: OT Other Discipline Involvement: PT |
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Service Need: Increase independence with Instrumental Activities of Daily Living (IADL)

Goal: Client will achieve maximum independence with or without support (s)

| Initial Assessment | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Occupational Therapy assessment and/or clinical reports –include a focused IADL assessment • Complete outcome measurement tool • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate potential timeline for recommended management or intervention • Obtain and document client's consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Client's current IADL status will be determined • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager's service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Identify adapted procedures/methods to perform IADLs • Identify equipment and/or resources (personal support services or caregiver support) if required • Order equipment for trial or identify where recommended equipment can be purchased • Teach adapted methods and /or use of equipment • Train caregivers if used as support • Evaluate trialed equipment for safety, usefulness and affordability • Facilitate purchase of equipment or funding application as required • Evaluate outcomes | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client will possess the necessary equipment or know how to access equipment in the future • Client will use the equipment safely • Client will integrate adapted procedures and methods taught in order to participate in IADLs • Client will achieve his/her maximum level of independence • The appropriate supports will be in place or client will know how to access home/volunteer services in their community • Intervention improves the quality of life for the |

| | |
|--|--|
| <ul style="list-style-type: none"> • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • client/caregiver/family • Client/family/SDM will understand the potential safety risks related to condition/situation |
|--|--|

| Discharge/Follow-up | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Occupational Therapy discharge assessment /report and outcome measurement tool • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have achieved his/her instrumental ADL goals • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> • Average Number of Visits 4-6 | <ul style="list-style-type: none"> • Number of Weeks on Service 6-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|--|--|
| Functional Issue: Wheelchair, seating | Primary Discipline: OT Other Discipline Involvement: PT |
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Service Need: Assess and prescribe appropriate wheelchair and seating for client

Goal: Client will have appropriate wheelchair and seating system

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Review medical history and information as appropriate Schedule initial visit with client/family/SDM Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) Complete/document Occupational Therapy assessment and/or clinical reports –include a mobility and seating assessment Determine ADP eligibility and describe process to client/caregiver/SDM Identify problem areas and concerns Identify need for other disciplines /services Develop SMART goals and treatment plan Evaluate potential timeline for recommended management or intervention Obtain and document client’s consent to proceed with intervention Communicate assessment findings to case manager | <ul style="list-style-type: none"> Assessment findings will facilitate the development of client/caregiver centred goals Client /SDM will understand and consent to needed intervention Client/caregiver will understand ADP eligibility criteria and prescription process Roles of the service provider, client, caregiver, SDM will be articulated and understood A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Provide education to client/caregiver regarding mobility assessment procedures, assistive devices program if appropriate, and/or other funding programs Decide if client could be eligible for ADP funding <ul style="list-style-type: none"> <u>If you are not an ADP authorizer and the client could be eligible for ADP funding:</u> Provide client with information on how to access an ADP authorizer for an assessment <ul style="list-style-type: none"> <u>If you are an ADP authorizer and the client is eligible or is not eligible but wishes to purchase a wheelchair:</u> Provide education on different wheelchairs and seating options and (ADP) vendors to facilitate trial and decision making by the client/SDM Identify wheelchairs and seating for trial | <ul style="list-style-type: none"> Client/caregiver is receiving optimal services including education/information related to identified needs Services are client specific Client will know how to contact ADP authorizer for an assessment when appropriate Client will understand mobility assessment procedures and procedures for funding when appropriate Client will possess the appropriate wheelchair and seating system |

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|---|--|
| <ul style="list-style-type: none"> • Order and trial wheelchair and seating systems • Make changes to wheelchair components or entire wheelchair and seating system as necessary to meet clients needs • Order new equipment for trial • Teach adapted methods and/or use of equipment • Train caregivers, on how to push client or adjust/operate wheelchair if appropriate • Facilitate purchase of equipment or funding application as required • Provide client with information of equipment vendor and process for obtaining the equipment once funding has been approved • Arrange for follow-up visit upon receipt of wheelchair • Evaluate outcomes • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • Client will know how to access the equipment vendor in the future • Client will achieve his/her maximum level of independence, comfort and accessibility with the new equipment • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential safety risks related to condition/situation |
|---|--|

| Discharge/Follow-up | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Occupational Therapy discharge assessment /report • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have an appropriate wheelchair and/or seating system • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> • Average Number of Visits 4-6 | <ul style="list-style-type: none"> • Number of Weeks on Service 4-16 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|-----------------------------------|---|
| Functional Issue: Mobility | Primary Discipline: PT Other Discipline Involvement: OT, Nursing |
|-----------------------------------|---|

Service Need: Client at risk for falls

Goal: Client will be safe with functional mobility within the home and community environment

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Physiotherapy assessment which includes the following elements: <ul style="list-style-type: none"> - home safety assessment - balance - L/E strength - endurance - transfers • Complete appropriate outcome tools • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Complete outcome measurement tools • Evaluate prognosis for improvement and potential timeline for recommended management or intervention • Obtain and document client's consent to proceed with treatment/intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager's service plan |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Implement care plan which includes transfer training, balance and strengthening exercises, gait training • Identify equipment and/or resources (personal support or caregiver relief) if required • Order equipment for trial, when appropriate • Educate, train the client and primary caregivers regarding safety issues, risk factors and | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client will demonstrate understanding of appropriate level of assistance required for safe transfer/mobility/ambulation • Client/caregiver will demonstrate safe |

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| <p>intervention strategies</p> <ul style="list-style-type: none"> • Evaluate equipment for safety, usefulness and affordability • Facilitate purchase of equipment or funding application as required • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <p>ambulation/transfer techniques</p> <ul style="list-style-type: none"> • Client will have purchased or arranged for ongoing rental of the necessary equipment (or know how to access equipment in the future) • Intervention improves the quality of life for the client/caregiver/family • Client/family/SDM will understand the potential safety and medical risks related to condition/diagnosis |
|--|--|

| Discharge/Follow-up | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Physiotherapy discharge assessment /report and outcome measurement tool • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have achieved the identified goals • Client will be safe with functional mobility in the home and community • Client/caregiver is informed and/or linked to alternative community resources where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> • Average Number of Visits 6-8 | <ul style="list-style-type: none"> • Number of Weeks on Service 4-10 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|--|---|
| Functional Issue: Shoulder Pain | Primary Discipline: PT Other Discipline Involvement: OT, Nursing |
|--|---|

Service Need: Client at risk for developing or has shoulder pain

Goal: Prevent or decrease shoulder pain and limitations secondary to pain

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Complete/document Physiotherapy assessment which includes the following elements: <ul style="list-style-type: none"> - range of motion - tone - sensation - pain level - motor recovery stage - strength (if appropriate) - upper extremity function • Complete appropriate outcome measurement tools • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management or intervention • Obtain and document client's consent to proceed with treatment/intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager's service plan |

| Intervention | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Implement care plan which includes: • pain alleviating modalities e.g. ultrasound, acupuncture • range of motion exercises • prescription of supportive devices if required e.g. lap tray • postural/resting position corrections | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Services are client specific • Client /caregiver will understand positioning/postural influences on shoulder pain • Client/caregivers will demonstrate safe handling techniques to minimize aggravation of |

| | |
|---|--|
| <ul style="list-style-type: none"> Educate, train the client and primary caregivers regarding proper positioning, handling, and movement of upper extremity Educate re: adaptive techniques to decrease painful activities of daily living Evaluate outcomes Re-assess and update treatment goals on an ongoing basis Liaise with other health professionals as required Begin discussion with client/caregiver regarding discharge | <p>overstretched or tight shoulder complex</p> <ul style="list-style-type: none"> Client/caregiver will have explored adaptations to accommodate and minimize shoulder pain during ADL Intervention improves the quality of life for the client/caregiver/family Client/caregiver will understand the potential safety risks related to the condition |
|---|--|

| Discharge/Follow-up | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> Evaluate goal attainment Evaluate pain modulation techniques Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment Communicate discharge plans to case manager and any relevant disciplines Complete Physiotherapy discharge assessment/report and outcome measurement tool Determine ongoing needs for further service/continuity of care Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> Client will have achieved the identified goals Client/caregiver is independent in minimizing/preventing shoulder pain Client/caregiver is informed and/or linked to alternative community resources where appropriate Client/caregiver is satisfied with service and outcomes Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|--|
| <ul style="list-style-type: none"> Average Number of Visits 4-6 | <ul style="list-style-type: none"> Number of Weeks on Service 1-4 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

| | |
|--|---|
| Functional Issue: Family/Social Support | Primary Discipline: SW Other Discipline Involvement: OT, Nursing |
|--|---|

Service Need: Client/caregiver impacted by adjustment to altered health status

Goal: Client/caregiver will develop strategies to enhance coping and Facilitate adjustment to altered health status of client

| Initial Assessment | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release o information (determine if client capable to consent) • Assess pre-event history of family interaction, roles, status and coping. Review impact of altered health status and functioning on caregiver system from client and caregiver system perspective • Use appropriate tools to assess family/caregiver coping and functioning e.g. Caregiver Burden Screen, Caregiver Abuse Screen, Elder at Risk for Abuse Screen, Geriatric Depression Scale, Safety Plan, Stroke Aphasia Depression Questionnaire etc. • Review current level of family interaction, family roles and adaptations, POA, problem solving capabilities, financial status, current and future planning needs • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management or intervention • Obtain and document client’s consent to proceed with intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Client and caregiver system will identify potential risks and crisis points • The client and caregiver system will effectively communicate about the impact of the health event on them • The client and caregiver system will effectively communicate about the impact of the health event on them • The caregiver/family will differentiate between constructive and destructive coping interaction behaviours • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan |

| Intervention | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Develop strategies to facilitate coping via community resources, education regarding altered health status and family roles, strategies to support respite and needs of caregiver system, and medium to long term strategies to sustain coping | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information/counseling related to identified needs • Services are client specific • Application and referral to appropriate community resources to support and facilitate |

| | |
|--|--|
| <ul style="list-style-type: none"> • Intervention strategies may include: • Cognitive Behavioural Therapy, Structural Therapy, Narrative Therapy, Solution Focused Therapy, Existential Therapy etc. to foster understanding and enhance coping • Provide education and resource information to identify behavioural benchmarks in the recovery process, to provide support as well as sustain and /or bolster coping in the recovery process • Develop a Crisis Management Plan with the client and caregiver in the event of destabilizing of family/caregiver system • Refer for therapeutic counseling for caregiver/family system, if required • Link with appropriate community supports that will support and sustain coping • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <p>coping will be initiated</p> <ul style="list-style-type: none"> • Therapeutic intervention will facilitate change and adaptation and provide insight to caregiver/family system and client • Client and caregiver system will be informed about benchmarks in the recovery process • Family/caregiver will be informed about appropriate supports in the event of a family crisis or need for respite, Day Programs, shelter options, in-home support options • Intervention improves the quality of life for the client/caregiver/family |
|--|--|

| Discharge/Follow-up | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete required Social Work discharge assessment/reports and outcome measurement tools • Review post-level intervention level of client and caregiver system coping • Review risk factors for client and caregiver system • Determine ongoing needs for further service/continuity of care • Advocate and facilitate linkage with community supports as needed | <ul style="list-style-type: none"> • Client/caregiver system will have achieved the identified goals • All relevant parties are informed of the discharge plans • Future planning needs for client and family/caregiver will be reviewed, revised and appropriate linkages initiated to optimize safety and avert crisis for family/caregiver/client • Effective problem-solving capabilities will be demonstrated • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|--|---|
| <ul style="list-style-type: none"> • Average Number of Visits 1-8 | <ul style="list-style-type: none"> • Number of Weeks on Service 1-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|--|--|
| Functional Issue: Mood Disorder | Primary Discipline: SW Other Discipline Involvement: OT, PSW, Nursing |
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Service Need: Client exhibiting altered mood status impacting coping (depression, anxiety, suicidal ideation, withdrawal, mania)

Goal: Client will develop strategies to manage labile mood

| Initial Assessment | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Schedule initial visit with client/family/SDM • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Assess impact of altered health status and risk assessment on coping and behaviour from client and caregiver perspective • Determine pre-event history of mood status and coping • Use appropriate tools to assess mood, e.g. Cohen-Mansfield Aggression Scale, Beck Depression Scale, Geriatric Depression Scale (full or brief), and Suicidal Ideation inventory etc. • Identify problem areas and concerns • Identify need for other disciplines /services • Develop SMART goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management or intervention • Obtain and document client’s consent to proceed with treatment/intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Client /SDM will understand and consent to needed intervention • Roles of the service provider, client, caregiver, SDM will be articulated and understood • Assessment findings will provide information about the scope of the mood disorder and facilitate the development of client/caregiver centred goals • Client and caregiver system will identify potential risks and crisis points • The client will differentiate between constructive and destructive coping behaviours • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan • The client and caregiver system will understand the factors that have contributed to the current situation |

| Intervention | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Implement care plan • Develop strategies for effective management of mood and associated behaviours <ul style="list-style-type: none"> — Intervention strategies may include: — Cognitive Behavioural Therapy, Solution-Focused Therapy, Existential Therapy etc. to foster understanding and enhance coping • Provide education and resource information to | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information/counseling related to identified needs • Services are client specific • Client and caregiver system will be informed about benchmarks in the recovery process • Client and caregiver system will identify areas of strength, vulnerability, and triggers for |

| | |
|--|---|
| <p>identify mood destabilizers in the recovery process, to provide support as well as sustain and/or bolster coping in the recovery process</p> <ul style="list-style-type: none"> • Develop a Crisis Management Plan with the client in the event of an emotional crisis or manifestation of suicidal ideation, if required • Link with community supports • Evaluate outcomes • Re-assess and update treatment goals on an ongoing basis • Liaise with other health professionals as required • Refer for medical assessment for pharmacological management of mood, if required • Begin discussion with client/caregiver regarding discharge | <p>destabilizing mood</p> <ul style="list-style-type: none"> • A crisis management plan will be developed if required to facilitate coping with a behavioural/functional crisis • Management of mood disorder will be assessed medically • Appropriate referrals and applications will be initiated • Intervention improves the quality of life for the client/caregiver/family |
|--|---|

| Discharge/Follow-up | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client /family regarding reason for discharge and follow up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete required Social Work discharge assessment/reports and outcome measurement tool • Review risk factors for client and caregiver system • Determine ongoing needs for further service/continuity of care • Advocate and facilitate linkage with community supports as needed | <ul style="list-style-type: none"> • Client will have achieved the identified goals • All relevant parties are informed of the discharge plans • Client coping will be supported and facilitated by implementation of strategies and supports to sustain safety and coping to optimize mood stability • Client/caregiver is informed and/or linked to alternative community supports where appropriate • Client/caregiver is satisfied with service and outcomes • Client/family has contact names and numbers should further service be required |

| Service Guidelines | |
|---|--|
| <ul style="list-style-type: none"> • Average Number of Visits 2-8 | <ul style="list-style-type: none"> • Number of Weeks on Service 2-12 |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|--|--|
| Functional Issue: Communication | Primary Discipline: SLP Other Discipline Involvement: OT, Nursing, SW |
|--|--|

Service Need: **Compromised communication secondary to stroke**

Goal: **To improve level of functional communication**

| Initial Assessment | |
|---|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Communication assessment to include screening for the following elements: <ul style="list-style-type: none"> ○ expressive language disorder ○ receptive language disorder ○ apraxia ○ dysarthria ○ cognitive-communication disorder ○ voice disorder • Evaluate awareness and motivation to improve communication skills • Evaluate ability to respond to cueing strategies • Identify problem areas and concerns • Complete outcome measurement tools • Develop Smart goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management or intervention • Obtain and document client’s consent to proceed with treatment/intervention • Communicate assessment findings to case manager | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client/SDM will understand and consent to needed intervention • Roles of service provider, client, caregiver will be articulated and understood • Presence, absence and details of aphasia, apraxia, dysarthria and/or cognitive communication disorder will be determined • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager’s service plan • Recommendations for appropriate follow-up such as management, specific treatment strategies and/or discharge planning will be made |

| Intervention | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Educate client /caregiver regarding nature of aphasia, dysarthria and /or apraxia as relevant • Teach client/caregiver strategies and activities to improve communication (in practice and functional situations) • Evaluate precursors to use of an augmentative communication system • Develop personalized augmentative or alternative communication system as required, or facilitate loan or purchase of the same • Teach client and caregivers to maximize the | <ul style="list-style-type: none"> • Client/caregiver is receiving optimal services including education/information related to identified needs • Minimization of the impact of the communication impairment upon functional and psychosocial aspects of daily living • Services are client specific |

| | |
|--|---|
| <p>effectiveness of communication using the identified system</p> <ul style="list-style-type: none"> • Evaluate the communication environment: social, academic or vocational • Recommend modifications to maximize communication • Evaluate outcomes • Re-assess and update goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • Intervention improves quality of life for the client/caregiver/family |
|--|---|

| Discharge/Follow-up | |
|--|---|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Evaluate goal attainment • Provide information to the client/family regarding reason for discharge and follow-up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Speech Language Pathology discharge report and outcome measurement tool • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client will have achieved the identified goals • Client will have improved level of functional communication • All relevant parties are informed of the discharge plans • Client/caregiver is satisfied with service and outcomes • Client/caregiver is informed and /or linked to alternative community resources where appropriate • Client/ family has contact names and numbers should further service be required |

| Service Guidelines | |
|---|--|
| <ul style="list-style-type: none"> • Average Number of Visits Mild 2-12 Moderate 12-32 Severe - to be determined in collaboration with speech language pathologist | <ul style="list-style-type: none"> • Number of Weeks on Service Mild 2-12 Moderate – up to 6 months Severe – to be determined in collaboration with speech language pathologist |

Interventions/activities are client specific. All may not apply nor are they completed in the order documented.

COMMUNITY CARE ACCESS CENTRE STROKE BEST PRACTICE GUIDELINES

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|---|--|
| Primary Issue: Swallowing, Dysphagia | Primary Discipline: SLP Other Discipline Involvement: RD, OT, Nursing |
|---|--|

Service Need: Swallowing difficulty resulting in risk of aspiration, pneumonia and altered nutritional status

Goal: To decrease risk of aspiration and improve nutritional status

| Initial Assessment | |
|---|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Review medical history and information as appropriate • Obtain and document verbal consent – for assessment and release of information (determine if client capable to consent) • Schedule appointment at meal time or with typical mealtime foods and/or fluids available • Complete and document assessment that includes meal observation with full functional evaluation: <ul style="list-style-type: none"> - medical, developmental and swallowing history - current medical, swallowing and communication status - oral-motor and sensory assessment - swallowing foods and /or fluid trials as appropriate - trials of swallowing strategies • Teach, train and counsel the client and/or caregiver(s) regarding: <ul style="list-style-type: none"> - normal and disordered swallowing - assessment results - health risks, care plan and quality of life - written recommendations • Request referrals if required to: <ul style="list-style-type: none"> - DT - for follow-up on modified diet in relation to nutritional needs - OT – for feeding utensils - OT or PT - for positioning - NSG – to monitor chest • Complete appropriate measurement outcome tools • Identify problem areas and concerns • Develop Smart goals and treatment plan • Evaluate prognosis for improvement and potential timeline for recommended management or intervention • Obtain and document client's consent to | <ul style="list-style-type: none"> • Assessment findings will facilitate the development of client/caregiver centred goals • Client/SDM will understand and consent to needed intervention • Roles of service provider, client, caregiver will be articulated and understood • Presence, absence and details regarding abnormal oral swallow physiology according to the patient's age or developmental stage • Likelihood and potential details of abnormal pharyngeal, laryngeal or upper esophageal swallow physiology have been determined • Identification of potential risk for medical complications secondary to swallowing impairment • Potential impact of swallowing impairment on functional and psychosocial aspects of daily living • A treatment plan will be developed by the service provider in conjunction with the client/caregiver which complements/supports the case manager's service plan • Recommendations for appropriate follow-up such as management, specific treatment strategies and/or discharge planning will be made |

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| <ul style="list-style-type: none"> • proceed with treatment/intervention • Communicate assessment findings to case manager | |
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| Intervention | |
|---|--|
| Activities | Expected Outcomes |
| <p>Management plan will include:</p> <ul style="list-style-type: none"> • Compensatory strategies to direct bolus flow in a more efficient and safe manner • Environmental strategies to enhance compliance with compensatory strategies and increased awareness of swallowing • Education, training and counseling of the patient and/or caregiver regarding strategies, risk factors and danger signs <p>Provide treatment that may include:</p> <ul style="list-style-type: none"> • Compensatory strategies in management stage which complement and enhance physiology of the swallow • Exercises to improve oral motor functioning, timing efficiency and safety of swallow response • Exercise to improve laryngeal strength and coordination or respiration and phonation • Exercises or strategies to improve or promote the developmentally appropriate feeding and swallowing skills • Techniques to reduce oral hyposensitivity and hypersensitivity • Evaluate outcomes • Re-assess and update goals on an ongoing basis • Liaise with other health professionals as required • Begin discussion with client/caregiver regarding discharge | <ul style="list-style-type: none"> • Reduced risk of aspiration, through improved airway protection and increased efficiency • Reduction in clinical indicators of aspiration • Maximizing oral versus non-oral nutritional hydration intake when appropriate • Client/caregiver is receiving optimal services including education/information related to identified needs • Client/caregiver understand the potential risk for medical complications due to swallowing difficulties • Services are client specific • Intervention improves quality of life for the client/caregiver/family |

| Discharge/Follow-up | |
|--|--|
| Activities | Expected Outcomes |
| <ul style="list-style-type: none"> • Education of client/caregiver regarding the importance of early detection in change of swallowing status • Evaluate goal attainment • Provide information to the client/family regarding reason for discharge and follow-up plan or how to initiate re-assessment • Communicate discharge plans to case manager and any relevant disciplines • Complete Speech Language Pathology discharge report and outcome measurement tool • Determine ongoing needs for further service/continuity of care • Refer or recommend alternative community program/resources as appropriate | <ul style="list-style-type: none"> • Client/caregiver will be educated and will understand the clinical signs and the importance of early detection in change of swallowing status • Client will have achieved the identified goals and will have decreased risk of aspiration • Client will have improved nutritional status • All relevant parties are informed of the discharge plans • Client/caregiver is satisfied with service and outcomes • Client/caregiver is informed and /or linked to alternative community resources where appropriate • Client/ family has contact names and numbers should further service be required |

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| Service Guidelines |
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| <ul style="list-style-type: none">• Average Number of Visits 1-12 | <ul style="list-style-type: none">• Number of Weeks on Service 1-12 |
|---|---|

Interventions/activities are client specific. All may not apply nor are they completed in the order documented



Glossary

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|--------|---|--|
| ADL | - | Activities of Daily Living eg, toileting, dressing, feeding |
| CAPS | - | Client Assessment Protocol |
| IADL | - | Instrumental Activities of Daily Living eg. Shopping, banking |
| MD | - | Physician |
| MOH | - | Ministry of Health |
| OT | - | Occupational Therapist |
| PT | - | Physiotherapist |
| RAI-HC | - | Resident Assessment Instrument for Home Care |
| RD | - | Registered Dietician |
| SDM | - | Substitute Decision Maker |
| SLP | - | Speech Language Pathology |
| SW | - | Social Worker |
| TPN | - | Total Parenteral Nutrition |

On-line Resources re Stroke Care in the Community

Case Management Best Practices for Community Stroke Care

<http://bpp.oaccac.on.ca/strokestrategy/>

Tips and Tools for Everyday Living A Guide for Stroke Caregivers

<http://209.5.25.171/ClientImages/1/CSSTipsandTools.pdf>

Other Professional Resources through Heart and Stroke

<http://209.5.25.171/Page.asp?PageID=244&SubcategoryID=71&CategoryID=73>

Online Rehabilitation Education Program in Stroke

<http://bul.med.utoronto.ca/reps/>

SW Region Stroke Strategy

<http://www.lhsc.on.ca/rss/>

Ontario Stroke Nurses Network Downloadable resources

<http://209.5.25.171/ClientImages/1/Ontario%20Stroke%20Nursing%20Network%20Resource%20April%206%202005.pdf>