

Stroke Rehabilitation Candidacy Screening Tool

Instruction Package



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Introduction

Purpose of Package

The package has been designed to assist the study participants with the utilization of the *Stroke Rehabilitation Candidacy Screening Tool*.

This package also includes a job aid for quick reference when using the tool.

Learner Objectives:

The learner will understand:

1. the purpose of the *Stroke Rehabilitation Candidacy Screening Tool* and its components.
2. who can complete the tool
3. when the tool should be completed, and
4. how to complete the tool

Background

Access to specialized stroke rehabilitation is a best practice: **Canadian Stroke Strategy: Canadian Best Practice Recommendations for Stroke Care 2006**. All patients with stroke who are admitted to hospital and who require rehabilitation should be treated in a comprehensive or rehabilitation stroke unit by an interdisciplinary team (Evidence Level A/1).

The Southwestern Ontario Stroke Strategy led a *Stroke Rehabilitation Action Planning Day* in November 2006 to generate consensus on strategic directions for moving stroke rehabilitation toward best practice for SWO. One of the six top strategic priorities for the region was “Standardize assessment and triage criteria for equitable, timely access to designated inpatient stroke rehabilitation beds.” A working group to address this priority was created¹.

This working group designed the *Stroke Rehabilitation Candidacy Screening Tool* using standards and recommendations from the “Consensus Panel on the Stroke Rehabilitation System: Time is Function 2007” report to the Ministry of Health and Long-Term Care. Feedback was solicited from a wide spectrum of stakeholders across the region, contributing to multiple revisions of the tool.

You will notice this screening tool incorporates the Alpha FIM (see page 5).

¹ Members included: Deb Willems, Regional Stroke Rehabilitation Coordinator; Doris Noble, District Stroke Coordinator for Huron Perth; Marilee Garner, CCAC; Brenda Palsa, South Huron Hospital; Paula Gilmore, District Stroke Coordinator Sarnia-Lambton; Karen Atkins, Tillsonburg Memorial Hospital; Mary Cardinal, Huron Perth Healthcare Alliance.

Definitions:

Inpatient Stroke Rehabilitation: A specialized inpatient program of care providing comprehensive, coordinated and evidence-based stroke rehabilitation service delivered by an inter-professional team experienced in post stroke care.

Screening tool: A test or testing carried out routinely in order to identify, as early as possible, those with a particular problem or feature. RNAO Best Practice Guidelines² indicate that **screening tools** can augment, but not replace a comprehensive assessment. A common example of a screening tool is the Modified Mini-Mental State Examination used for cognitive screening.

Purpose of Stroke Rehabilitation Candidacy Screening Tool:

The purpose of the *Stroke Rehabilitation Candidacy Screening Tool* is to identify the eligibility and readiness of stroke clients for post-acute inpatient rehabilitation.

- ⇒ Based on the findings of the Screening Tool, a more detailed assessment may be required.
- ⇒ A Rehabilitation Referral/Transfer form will need to be completed separately.

Benefits of the Screening Tool:

- ⇒ Standardize admission criteria for inpatient stroke rehabilitation
- ⇒ Utilize a common language for functional status and rehabilitation needs
- ⇒ Incorporate stroke rehabilitation standards and recommendations into practice
- ⇒ Provide objective data regarding the rehabilitation service needs of stroke clients
- ⇒ Match the needs of the client with the appropriate service

Components of the Stroke Rehabilitation Candidacy Screening Tool:

There are **two** sections to the screening tool: *Rehabilitation Candidacy* and *Rehabilitation Readiness*.

Rehabilitation Candidacy includes five components:

- functional status
- ability to follow commands
- rehabilitation goals
- demonstrates change over time
- consent to participate in rehabilitation

These criteria identify candidates likely to benefit from rehabilitation.

Rehabilitation Readiness includes two components:

- tolerance
- medical stability

These criteria identify candidates who have the ability to participate in rehabilitation.

Optimally, patients should access post-acute stroke rehabilitation resources when they have achieved both of the above criteria: candidacy and readiness.

Please note that information about family/living situation is not included in the screening tool because the Consensus Panel on the Stroke Rehabilitation System guidelines indicates that “absence of adequate social support should not be used to deny access to stroke rehabilitation”.

² Nursing Best Practice Guideline: Screening for Delirium, Dementia and Depression in the Older Adult. *Registered Nurses Association of Ontario*, November 2003

Inpatient Stroke Rehabilitation Candidacy Screening Tool

Date of Stroke: _____

┌ Addressograph ┐
└────────────────┘

Part 1

Rehabilitation Candidacy:

Functional Status: AlphaFIM® Has the patient been observed walking 150 feet? Yes No

Please circle score for each item

Eating/Walking	1	2	3	4	5	6	7
Grooming/Bed transfer	1	2	3	4	5	6	7
Bowel Management	1	2	3	4	5	6	7
Toilet transfer	1	2	3	4	5	6	7
Expression	1	2	3	4	5	6	7
Memory	1	2	3	4	5	6	7

Motor conversion score: ____ Cognitive conversion score: ____ Total FIM score: ____/126

Help Needed: ____ hours

Date Part 1 completed: _____

Part 2

Ability to Follow Commands: Yes No Date achieved: _____

Verbal: "Close your eyes"

Nonverbal: Follows written command "Close your eyes" **and/or**

Follows addition of gestural cue for "Close your eyes"

Rehabilitation Goals: Does the patient have rehabilitation goals that require **inpatient** care?

NO → No goals Appropriate for community rehabilitation services

YES → specify; from your assessment, the patient requires inpatient rehabilitation to improve:

- | | |
|--|---|
| <input type="checkbox"/> communication | <input type="checkbox"/> return to oral diet (swallowing) |
| <input type="checkbox"/> arm and hand function | <input type="checkbox"/> self care (bathing, dressing, toileting) |
| <input type="checkbox"/> cognitive, perceptual ability | <input type="checkbox"/> continence (bowel/bladder control) |
| <input type="checkbox"/> mobility (transfers, ambulation, sitting with comfort) | |
| <input type="checkbox"/> ability to perform role (home & money management, organizational, socialization, vocational skills) | |
| <input type="checkbox"/> caregiver/family's ability to manage the patient's care after discharge | |
| <input type="checkbox"/> other: _____ | Date: _____ |

Demonstrates Change: Yes No Date achieved: _____

Demonstrates improvement in function over time that is related to rehabilitation goals.

Time over which change will be demonstrated will vary depending on the severity of the stroke.

Verbal Consent to Participate In Rehabilitation: Yes No Date: _____

Patient/Substitute Decision Maker has agreed to Rehabilitation Goals as identified above and indicates willingness to participate in rehabilitation intervention post acute care.

"If accepted, would you be willing to participate in rehabilitation services (cite relevant services e.g. PT, OT, SLP, SW or rehabilitation program) to (cite patient/family goals as listed above) after the doctors feel you are ready to leave this acute care service?"

Patient meets all candidacy criteria; should be considered for referral to inpatient rehabilitation: Yes No

Rehabilitation Readiness:

All qualifying candidates will be followed to determine when rehabilitation readiness is achieved as follows:

Tolerance: Tolerates a minimum of one hour sitting up in a wheelchair (or upright out of bed)

twice per day. Tolerance achieved: No Yes; Date: _____

Medical Stability:

To guide you in your decision about medical stability, please consider the following:

- MRP identifies that patient no longer requires acute care
- Cause of stroke explored; medical investigations completed or in process
- Secondary prevention/medication plan initiated
- Comorbid medical conditions managed/stable
- Patient is not palliative (life expectancy > 6 months)

Medical Stability achieved: No Yes; Date: _____

Readiness Achieved: No Yes

Date ready: _____

How to complete the form:

Not all criteria must be directly observed. It is acceptable to consult the patient's care team to obtain the necessary information.

Part 1

AlphaFIM®: Please score according to the AlphaFIM® Instrument Guide and FIM System Decision Trees **within 3 to 5 days of admission**. For the first two items: Eating/Walking and Grooming/Bed Transfer, please circle the items that were rated. You will need to enter the raw scores into the web-based system to get the conversion scores (see box below). Add the motor and cognition conversion scores for the Total FIM score. Please also note the hours of Help Needed.

AlphaFIM® Scoring System:

No Helper

7 Complete Independence (no device, timely, safely)

6 Modified Independence (device, not timely, or not safely)

Helper - Modified Dependence

5 Supervision (patient performs 100% of the effort)

4 Minimal Assistance (patient performs 75% or more of the effort)

3 Moderate Assistance (patient performs 50% to 74% of the effort)

Helper - Complete Dependence

2 Maximal Assistance (patient performs 25% to 49% of the effort)

1 Total Assistance

Entering the AlphaFIM® website to get the conversion scores:

Go to www.udsmr.org

1. Click on the tab "Software Portals" and select "AlphaFIM® Software Entry"
2. Complete login info as follows:

Facility Code: TT038

User Name:

Password:

Part 2

Based on the resulting FIM score classifying the stroke survivors' severity, an appropriate time frame will be selected for **final** completion of Part 2 (see "Demonstrates Change"). All items in Part 2 may be completed at any time, especially if achieved earlier, but the time frame is meant to specify the latest date for completion.

Ability to Follow Commands: Give the verbal command "close your eyes". If the patient does not respond appropriately, show them the written command "close your eyes". If the patient is still unable to respond appropriately, repeat the command verbally "close your eyes" and, while keeping your eyes open, point to your eyes and make a gesture to close them (four fingers horizontally lower as if lowering a blind). Do not close your eyes as this would be testing the patient's ability to copy your action versus follow a command.

Rehabilitation Goals: Please check off any goals that, based on your assessment and clinical judgment, apply to the patient and require treatment in an **inpatient** rehabilitation setting. Community rehabilitation services refer to any rehabilitation services provided for patients living in the community, including ambulatory (outpatient, clinic, day hospital, community health centre) or home-based (CCAC) services.

Demonstrates Change: improvement in function over time that is **related to** rehabilitation goals.

The time over which change in function should be observed is based on stroke severity as follows:

Mild (FIM>80) over 3 days

Moderate (FIM 40-80) over 7 days

Severe (FIM <40) over 14 days

Verbal Consent to Participate in Rehabilitation: Obtain the patient/substitute decision maker's consent using the question provided in the tool.

Candidacy: Patient meets all criteria above. Select Yes, if the patient is able to follow commands, has rehab goals, demonstrates change over time and consents to participate according to the criteria above. The AlphaFIM score will be used to select the appropriate service.

Readiness:

Tolerance: Identify the length of time that a patient is able to tolerate sitting up out of bed in a wheelchair by observation, or from discussion with the patient's care team, to determine if they meet the minimum requirement. 'Tolerate' refers to remaining awake and alert, and reasonably comfortable.

Medical Stability: The points under medical stability are meant to guide you in your decision. It is not meant to be a checklist. MRP refers to the most responsible physician. Select yes or no based on the information you are able to gather from the chart and patient care team. Patients designated ALC should meet the criterion.

Instructions for Completion

AlphaFIM®: Please score according to the AlphaFIM® Instrument Guide and FIM System Decision Trees. For the first two items: Eating/Walking and Grooming/Bed Transfer, please circle the items that were rated. You will need to enter the raw scores into the web-based system to get the conversion scores (see page 10).

Ability to Follow Commands: Give the verbal command “close your eyes”. If the patient does not respond appropriately, show them the written command “close your eyes”. If the patient is still unable to respond appropriately, repeat the command verbally “close your eyes” and, while keeping your eyes open, point to your eyes and make a gesture to close them (four fingers horizontally lower as if lowering a blind). Do not close your eyes as this would be testing the patient’s ability to copy your action versus follow a command.

Rehabilitation Goals: Please check off any goals that, based on your assessment and clinical judgment, apply to the patient and require treatment in an **inpatient** rehabilitation setting.

Demonstrates Change: Improvement in function over time that is **related to** rehabilitation goals. The time over which change in function should be observed is based on stroke severity as follows:

- Mild (FIM>80) over 3 days
- Moderate (FIM 40-80) over 7 days
- Severe (FIM <40) over 14 days

Candidacy: Patient meets all criteria above. Select Yes, if the patient is able to follow commands, has rehab goals and demonstrates change over time according to the criteria above. The AlphaFIM score will be used to select the appropriate service.

Verbal Consent to Participate in Rehabilitation: Obtain the patient/substitute decision maker’s consent using the question provided in the tool.

Tolerance: Identify the length of time that a patient is able to tolerate sitting up out of bed in a wheelchair by observation, or from discussion with the patient’s care team, to determine if they meet the minimum requirement. ‘Tolerate’ refers to remaining awake and alert, and reasonably comfortable.

Medical Stability: The points under medical stability are meant to guide you in your decision. It is not meant to be a checklist. MRP refers to the most responsible physician. Select yes or no based on the information you are able to gather from the chart and patient care team.

Additional information....

Who will complete the form:

The intent is for **acute care staff** to complete the form. Persons completing the form will need to be trained in how to use the tool and credentialed in the use of AlphaFIM. It is recommended that this person be an **allied health professional or dedicated stroke nurse**.

When to complete the form:

You will notice that there are two parts to the tool (Part 1 and Part 2). Part 1, Rehabilitation Candidacy/ Functional Status, is measured using the AlphaFIM. The AlphaFIM must be completed within 3 to 5 days of admission.

Based on the resulting FIM score classifying the stroke survivors’ severity, the criteria for Demonstrates Change will provide a time frame within which to complete Part 2 (see section “Demonstrates Change”).

Any section of Part 2 may be completed at any point in time. The time frames identified in the section “Demonstrates Change” are recommended as maximum time frames for the majority of cases.

How to complete the form:

Not all criteria must be directly observed. It is acceptable to consult the patient’s care team to obtain the necessary information.

Stroke Rehabilitation Candidacy Screening Tool

Date of Stroke: _____

Part I

Rehabilitation Candidacy: Has the patient been observed walking 150 feet? Yes No
Functional Status: AlphaFIM® Please circle score for each item

Eating/Walking	1	2	3	4	5	6	7
Grooming/Bed Transfer	1	2	3	4	5	6	7
Bowel Management	1	2	3	4	5	6	7
Toilet transfer	1	2	3	4	5	6	7
Expression	1	2	3	4	5	6	7
Memory	1	2	3	4	5	6	7
Motor conversion score: ____	Cognitive conversion score: ____		Total FIM score: ____/126				

Help Needed: ____ Date Part 1 completed: _____

Ability to Follow Commands: Yes No

Verbal: "Close your eyes"

Nonverbal: Follows written command "Close your eyes" **and/or**

Follows addition of gestural cue for "Close your eyes"

There are two parts to the tool. Completion of the first part sets the time frame for Part 2.

Part 2

Ability to Follow Commands: Yes No

Verbal: "Close your eyes"

Nonverbal: Follows written command "Close your eyes" **and/or**

Follows addition of gestural cue for "Close your eyes"

Rehabilitation Goals: Does the patient have rehabilitation goals that require **inpatient** care?

NO → No goals Appropriate for community rehabilitation services

YES → specify; from your assessment, the patient requires inpatient rehabilitation to improve:

- communication
- arm and hand function
- cognitive, perceptual ability
- mobility (transfers, ambulation, sitting with comfort)
- ability to perform role (home & money management, organizational, socialization, vocational skills)
- caregiver/family's ability to manage the patient's care after discharge
- other: _____
- return to oral diet (swallowing)
- self care (bathing, dressing, toileting)
- continence (bowel/bladder control)

Demonstrates Change: Yes No Date achieved: _____

Demonstrates improvement in function over time that is related to rehabilitation goals.

Time over which change will be demonstrated will vary depending on the severity of the stroke.

Patient meets all criteria above and should be considered a candidate for rehabilitation: Yes No

Verbal Consent to Participate In Rehabilitation: Yes No Date: _____

Patient/Substitute Decision Maker has agreed to Rehabilitation Goals as identified above and indicates willingness to participate in rehabilitation intervention post acute care.

"Would you be willing to participate in rehabilitation services (cite relevant services e.g. PT, OT, SLP, SW or rehabilitation program) to (cite patient/family goals as listed above) after the doctors feel you are ready to leave this acute care service?"

Rehabilitation Readiness:

All qualifying candidates will be followed to determine when rehabilitation readiness is achieved as follows:

Tolerance:

Tolerates a minimum of one hour sitting up in a wheelchair (or upright out of bed) twice per day.

Tolerance achieved: No Yes; Date: _____

Medical Stability:

To guide you in your decision about medical stability, please consider the following:

- MRP identifies that patient no longer requires acute care
- Cause of stroke explored; medical investigations completed or in process
- Secondary prevention/medication plan initiated
- Co morbid medical conditions managed/stable
- Patient is not palliative (life expectancy > 6 months)

Medical Stability achieved: No Yes; Date: _____

Readiness Achieved: No Yes Date ready: _____

Motor and Cognitive scores calculated from website: www.udsmr.org
Add these for Total FIM. See p. 10 of pkg for instructions.

Alpha FIM must be completed within 3-5 days of admission

Severity is determined by AlphaFIM score. See page 6 for time frames.

Use this question to obtain patient consent.

MRP= Most Responsible Physician

These points act as guides only, not meant to be a checklist

AlphaFIM® Website Data Entry:

Go to www.udsmr.org

Click on the tab "Software Portals" (medium blue banner across the top) and select "AlphaFIM® Software"

You will see a green screen.

Complete login info as follows:

Facility Code: TT038

Username:

Password:

If the Information Area (right side of the page) does not have a green banner with the heading "AlphaFIM® Instrument", click on the 'Listing' button in the Navigation Area (left side of the screen)

Click on Add button in the Information area. Enlarge this screen by clicking on in top right hand corner.

Enter facility identifier into Patient ID field.

Enter the Birth Date by typing in month/day/year or using the calendar icon to the right.

Enter the Assessment date in the same manner. All other fields can be left blank.

Scroll down and answer the question: Has the patient been observed walking 150 feet or more? as yes/no using the drop down menu.

Scroll down and enter the 'Raw Ratings' of the 6 AlphaFIM items you have scored using the drop down menus (small arrows on the right of each box).

After entering the 6 item scores, click on the orange '**Calculate**' button.

Then go to the top of the page and click on the '**Print**' button.

Ensure it has printed, and double check that all values were entered correctly. Then cancel or close. Do not save.

On the left side, or Navigation Area, click on **Sign out**.

FAQs

1. What does the AlphaFIM® score mean? Why is it not a sum out of 42?

UDSmr has used its extensive database to develop an algorithm that uses the observed item ratings (6 items each scored out of 7) to infer ratings for unobserved items (all 18 items in the FIM: 13 Motor and 5 Cognitive). Hence, projections from ratings of the AlphaFIM items are estimates of concurrent FIM raw ratings for the motor and cognition items, expressed in terms of the range from total dependence to complete independence. Motor Score out of 91 and Cognitive Score out of 35; added together for a FIM Score out of 126.

2. What is a Rasch Score?

This is a statistical conversion to make the scores out of 100 providing a percentage of the maximum score that could be achieved.

3. What if the patient is unconscious/unable to participate within the first 3 to 5 days?

The AlphaFIM® takes this into account. It will indicate that a patient has sustained a severe stroke. This does not exclude the patient from qualifying as a Rehabilitation Candidate. The other criteria will be used to determine if the candidate qualifies for rehabilitation; particularly 'Demonstrates Change'. A re-scoring of the AlphaFIM may be used to determine the criteria 'Demonstrates Change'.

4. Why do we not ask about participation in therapy?

Because therapy is not always available in community hospitals, and we wanted this tool to be generalizable to those settings, we chose to assess an individual's ability to participate in therapeutic activity as simply activity tolerance. Activity tolerance is defined as an individual's ability to sit upright out of bed. Being out of bed in a wheelchair is preferable, but again, not always available in every setting.

5. What if the patient fails (e.g. is apraxic and cannot follow commands) and we think they should receive rehab?

The tool is meant to screen only (see definition of screening tool page 5). This means that in the majority of cases it should provide direction about whether to have a full assessment or not; i.e. in general a patient who is unable to follow commands would not be considered a rehabilitation candidate. However there will be some unusual cases called 'false negatives'. If you feel that for any reason a patient should be referred for a more in depth assessment for rehabilitation, please go ahead and do so.

6. What if a patient is not a rehabilitation candidate, can we do the screen again at a later date?

Yes, especially if severely affected, patients can be followed and referred if or when they achieve the criteria for inpatient rehabilitation candidacy.

Planning for Implementation

Who will complete the tool?	
When will it be completed?	
How will we ensure we capture all stroke admissions?	
What unique identifier will be used for the facility in the AphaFIM® Patient ID?	
How will it be documented/stored? <ul style="list-style-type: none">• Keep on chart, stored in Health Records<ul style="list-style-type: none">→ Do we need to track?• Keep in file	
When will we begin to implement it?	
What inservice education is needed for ward staff? <ul style="list-style-type: none">• Poster• PowerPoint	
Who else needs to know?	