Occupational Therapy Care for Stroke Survivors
Quick Reference Guide and Assessment Checklist
(COVID-19 Pandemic)

This document is intended to guide and support Occupational Therapists who may have limited experience working with stroke patients. It provides a summary of the care guidelines and assessments required to support stroke survivors during the acute and Rehabilitation phase of their recovery.

A. For basic information on stroke, refer to the Stroke 101 document

B. Stroke Assessment:

Within 24 hours:

- ❑ Dysphagia screening completed by trained professional

Within 48 hours:

- ❑ Initial OT assessment **and formulation of a management plan.**
- ❑ Clinicians should use standardized valid assessment tools and functional observation to evaluate the patient's stroke-related impairments. See Canadian Stroke Best Practice screening/assessment tools recommendations. See list of **common** Screening/ Assessment tools used by OT's in the below checklist.
- ❑ Refer to Occupational Therapy (OT) Stroke assessment checklist below
- ❑ Discharge planning should begin as early as possible

Within 72 hours:

- ❑ For patients in the acute phase of their stroke, the AlphaFIM® assessment (if credentialed), should be completed on or by Day 3. Components filled out by OT will vary by site but will generally include. If **not credentialed,** connect with a credentialed co-worker to assist in completing the AlphaFIM or talk to your leader **(Reminder: patients on droplet isolation are scored as "non-walkers").**

OR

- ❑ For patients in the inpatient rehabilitation phase of their stroke, the AlphaFIM® assessment (if credentialed), should be completed within **72 hours of admission** AND again at **discharge**. Components filled out by OT will vary by site but will generally include "Social Cognition" and/or "Self-Care".

FIM Instrument Overview.pdf

C. General Principles for Best Practice during Inpatient Acute and Rehabilitation Phase

Acute phase

- ❑ All stroke patients admitted to hospital with acute stroke should be mobilized between 24hours and 48 hours of stroke onset **unless contraindicated.**
- ❑ The team should promote the practice and transfer of skills gained in therapy into the patient's daily routine during inpatient stay.
- ❑ Education and enabling self-management for people with stroke, their families and caregivers, should be included as part of all healthcare encounters, and during transitions. Education provided by staff should be documented.
- ❑ Staff should be aware of methods to support communication with persons impacted by aphasia and other communication disorders (See Education section for training).

Inpatient Rehabilitation Phase

- ❑ Therapists should strive towards the target of 180 min of therapy daily per patient across all core disciplines (OT, PT, SLP and Therapist assistant). Provision of therapy should be intensive, 1:1, face-to-face and goal-directed.
- ❑ Therapy should include repetitive and intense use of patient-valued tasks that challenge the patient to acquire the necessary skills needed to perform functional tasks and activities. The team should promote the practice and transfer of skills gained in therapy into the patient's daily routine during inpatient stay.
- ❑ Education and enabling self-management for people with stroke, their families and caregivers, should be included as part of all healthcare encounters, and during transitions. Education provided by staff should be documented.
- ❑ Staff should be aware of methods to support communication with persons impacted by aphasia and other communication disorders (See Education section for training).
- ❑ FIM score will determine the patient's stroke severity, known as "Rehabilitation Patient Group", which allows to determine patient target length of stay.

Rehabilitation Patient Group (RPG)	Benchmark LOS (days)
1000 Mild	48.9
1100 Mild	41.8
1200 Moderate	35.8
1300 Moderate	25.2
1400 Moderate	14.7
1150 Mild	7.7
1160 Mild	0

******* *Given the unprecedented demands that COVID may require of the system, the above LOS targets may need to be altered. It may be prudent to alter the discharge goals for inpatient therapy such that patients, are discharged when they are* ***safe and able to continue their care in a virtual rehab model****. As such, teams should be functioning within an Early Supported Discharge paradigm.*

D. Discharge planning:

- ❑ Discharge planning should include the interprofessional team, the patient and caregiver/family.
- ❑ Deliver timely and comprehensive information, education and skills training to all patients and their family and/or caregivers.
- ❑ Does patient meet the eligibility criteria for inpatient rehabilitation or post-hospital rehabilitation services?

Inpatient Rehabilitation	**Post-Hospital Rehabilitation services** **Programs accepting applications during COVID-19 are mostly available through virtual care.*
• Would benefit from interdisciplinary rehabilitation assessment and treatment from staff with stroke expertise • Goals for rehabilitation can be established • Medical stability • The patient demonstrates the ability to participate in rehab • Care needs cannot otherwise be met in the community	• Patient has functional goals that individual/intensive therapy • Medical stability • Patient can manage safely in their home environment with or without HCC • Patient has family supports • Primary rehabilitative needs can mostly be met in the community within a virtual care model of care with or without the assistance of a caregiver.

- **YES? -**liaise with stroke team to make referral to appropriate inpatient, outpatient or community rehab program. See table for programs in the Southwest (SW) and Erie St-Clair (ESC).

- **NO? -**Continue to monitor and assess rehabilitation needs, collaborate with the patient, family, caregiver and the interprofessional team to determine an appropriate discharge plan and link to appropriate community resources (e.g. CNIB, March of Dimes Canada, etc.).

Inpatient, Outpatient and Community Rehab programs in the SW and ESC		
Inpatient Stroke Rehabilitation Programs		
Parkwood Institute, London	Woodstock General Hospital	St-Thomas Elgin General Hospital
Huron Perth– **temporarily located in Seaforth*	Grey Bruce – Owen Sound Hospital	Hotel Dieu Grace Healthcare, Windsor
Bluewater Health, Sarnia	Chatham Kent Health Alliance-Chatham Campus	
Outpatient Programs		
Comprehensive Outpatient Rehabilitation Program – Parkwood Institute, London ***Services provided virtually; in-person visits by exception*	Intensive Rehabilitation Outpatient Program – Woodstock **referrals accepted internally only at this time* ***Services provided face to face or/and via phone*	
Transitional Stroke Program – Chatham **referrals not accepted at this time*	Community Reintegration Program – Sarnia **services provided virtually*	Windsor Outpatient Program - Hotel Dieu Grace, Windsor
Community Rehabilitation Programs		
Community Stroke Rehabilitation Team (London, Middlesex, Elgin & Oxford; Grey Bruce; Huron Perth) ***Services provided virtually; in-person visits by exception*	Community Outreach Team, Hotel Dieu Grace Healthcare, Windsor **services provided virtually*	eRehab program (Windsor and Chatham) **services provided in person and virtually*

E. Patient & Family Information & Education

Education and Information is the responsibility of the entire health care team.
Ensure that you are keeping the patient, and their family members/caregivers apprised of all aspects of care and are providing any necessary education.
Education starts in the ER and continues throughout the inpatient phase into the community.

Key education resources include

- ✓ Canadian Stroke Best Practices
- ✓ Heart and Stroke's post stroke checklist (See Appendix A)
- ✓ Hospital specific Stroke Education resources (e.g.: Your Stroke Journey, etc.)
- ✓ Key Stroke care providers (educators, staff on stroke unit, manager) can direct you to education resources that are typically used
- ✓ Community Stroke resources on the SW Healthline and ESC Healthline
- ✓ Supported Conversation for Adults with Aphasia (SCA™) training module
- ✓ See Supplementary tool: Management of UE, Cognition and Perceptual impairment

PDF
BP Management of
UE Cogition & Visual

Prior to seeing the patient consider the following during the chart review

- Is the patient medically stable?
- Are the activity orders? Patient must have AAT orders
- Are their comorbidities, complications and/ or outstanding/pending medical procedures
- Are there any parameters you need to be aware of (e.g. BP, oxygen saturation, HR etc.)
- DVT/PE concerns
- Code status
- Collaborate with and/or review interprofessional team members' notes (swallowing status, communication deficits transfers, behaviour etc.)

Initial and Ongoing Assessments			
Functional			
☐ ADL/functional assessment	☐ Postural control	☐ Functional mobility	
☐ UE functioning (e.g. tone, ROM, strength, sensation, coordination etc.)	☐ Seating ☐ Assistive devices	☐ Functional cognition	☐ Other
Cognition (learning & ability to participate in rehabilitation) and visual perception. *Standardized cognitive screening must be completed			
☐ Attention (e.g. sustained, etc.)	☐ Memory	☐ Awareness	☐ Visual perception
☐ Follows directions (e.g. verbal, gestures, tactile, etc)	☐ Cognitive tolerance	☐ Other (impulsivity, executive function, etc.)	
Shoulder pain: *Note: The shoulder should not be passively moved beyond 90 degrees of flexion and abduction unless the scapula is upwardly rotated and the humerus is laterally rotated*			
☐ Presence of pain / exacerbating factors	☐ Edema (dorsum of digits)	☐ ↓ROM (external rotation)	
☐ Soft tissue or ortho changes/joint alignment (e.g. shoulder subluxation)	☐ Hyperaesthesia or trophic skin changes	☐ Appropriate positioning (e.g. in bed, in chair etc.)	☐ Other
Assess risk for falls & possible contributors			
☐ Functional (e.g. mobility, balance)	☐ Cognition	☐ Environment	
☐ Perception (e.g. visual, sensory etc.)	☐ Medical (e.g. cardiovascular)	☐ Other e.g incontinence	
Depression and post-stroke fatigue			
☐ Mood / Psychosocial concerns		☐ Post-stroke fatigue	

Provide education to patient, family and caregiver on the following			
☐ Current status (function, cognition, etc.) & recommendations (e.g. positioning, ROM etc.)	☐ Guide to Stroke Recovery (provide copy or link)	☐ Other	
Home environment			
☐ Access	☐ Equipment	☐ Support	☐ Other
IADL's			
☐ Meal Prep	☐ Med management	☐ Phone use	
☐Driving/ transportation	☐ Finances	☐ Other	

Commonly used Screening/Assessment tools in Stroke Care		
Cognition	**Visual/Perceptual**	**Upper Extremity**
-MOCA	-OSOT -BIT -MVPT -Comb and Razor Test -CDT -Line Bisection Test -Star cancellation -Trails A and B	-Chedoke McMaster Stroke Assessment -Fugl Meyer -Chedoke McMaster Arm and Hand Inventory (CAHAI) -Grip and Pinch strength -Modified Ashworth Scale (Spasticity) -Tardieu Scale (Spasticity)

SWOSN extends thanks to the other Ontario Stroke Networks who have contributed to the development of these documents.

Stroke Network Southwestern Ontario
Serving Erie St. Clair and South West LHINs

Canadian Stroke Best Practices

Post-Stroke Checklist

Developed by the Global Stroke Community Advisory Panel (2012), endorsed by the World Stroke Organization, adapted by the Heart and Stroke Foundation Canadian Stroke Best Practice Recommendations development team (2014)

Patient Name: _____ **Date Completed:** _____

Completed by: ◯ Healthcare Provider ◯ Patient ◯ Family Member ◯ Other

Since Your Stroke or Last Assessment

1 Secondary Prevention		
Have you received medical advice on health-related lifestyle changes or medications to prevent another stroke?	**NO** ◯	Refer patient to primary care providers for risk factor assessment and treatment if appropriate, or secondary stroke prevention services.
	YES ◯	**Continue to monitor progress**
2 Activities of Daily Living (ADL)		
	NO ◯	**Continue to monitor progress**
Are you finding it more difficult to take care of yourself?	**YES** ◯	Do you have difficulty: ◯ dressing, washing, or bathing? ◯ preparing hot drinks or meals? ◯ getting outside? If **Yes** to any, consider referral to home care services; appropriate therapist; secondary stroke prevention services.
3 Mobility		
	NO ◯	**Continue to monitor progress**
Are you finding it more difficult to walk or move safely (i.e., from bed to chair)?	**YES** ◯	Are you continuing to receive rehabilitation therapy? ◯ **No.** Consider referral to home care services; appropriate therapist; secondary stroke prevention services. ◯ **Yes.** Update patient record; review at next assessment.
4 Spasticity		
	NO ◯	**Continue to monitor progress**
Do you have increasing stiffness in your arms, hands, or legs?	**YES** ◯	Is this interfering with activities of daily living? ◯ **No.** Update patient record; review at next assessment. ◯ **Yes.** Consider referral to rehabilitation service; secondary stroke prevention services; physician with experience in post-stroke spasticity (e.g., physiatrist, neurologist).
5 Pain		
	NO ◯	**Continue to monitor progress**
Do you have any new pain?	**YES** ◯	Ensure there is adequate evaluation by a healthcare provider with expertise in pain management.
6 Incontinence		
	NO ◯	**Continue to monitor progress**
Are you having more problems controlling your bladder or bowels?	**YES** ◯	Consider referral to healthcare provider with experience in incontinence; secondary stroke prevention services.

Since Your Stroke or Last Assessment

7 Communication Are you finding it more difficult to communicate?	NO ◯		**Continue to monitor progress**
	YES ◯		Consider referral to speech language pathologist; rehabilitation service; secondary stroke prevention services.
8 Mood Do you feel more anxious or depressed?	NO ◯		**Continue to monitor progress**
	YES ◯		Consider referral to healthcare provider (e.g., psychologist, neuropsychologist, psychiatrist) with experience in post-stroke mood changes; secondary stroke prevention services.
9 Cognition Are you finding it more difficult to think, concentrate, or remember things?	NO ◯		**Continue to monitor progress**
	YES ◯	Is this interfering with your ability to participate in activities?	◯ **No.** Update patient record; review at next assessment. ◯ **Yes.** Consider referral to healthcare provider with experience in post-stroke cognition changes; secondary stroke prevention services; rehabilitation service; memory clinic.
10 Life After Stroke Are you finding it more difficult to carry out leisure activities, hobbies, work, or engage in sexual activity?	NO ◯		**Continue to monitor progress**
	YES ◯		Consider referral to stroke support organization (local/provincial support group, Heart and Stroke Foundation of Canada Living with Stroke program); leisure, vocational, or recreational therapist.
11 Personal Relationships Have your personal relationships (with family, friends, or others) become more difficult or strained?	NO ◯		**Continue to monitor progress**
	YES ◯		◯ Schedule next primary care visit with patient and family member(s) to discuss difficulties. ◯ Consider referral to stroke support organization (local/provincial support group, Heart and Stroke Foundation of Canada); healthcare provider (e.g., psychologist, counsellor, therapist) with experience in family relationships and stroke.
12 Fatigue Are you experiencing fatigue that is interfering with your ability to do your exercises or other activities?	NO ◯		**Continue to monitor progress**
	YES ◯		◯ Discuss fatigue with Primary Care provider. ◯ Consider referral to home care services for education and counselling.
13 Other Challenges Do you have other challenges or concerns related to your stroke that are interfering with your recovery or causing you distress?	NO ◯		**Continue to monitor progress**
	YES ◯		◯ Schedule next primary care visit with patient and family member(s) to discuss challenges and concerns. ◯ Consider referral to healthcare provider; stroke support organization (local or provincial support group, Heart and Stroke Foundation of Canada).

For more information refer to heartandstroke.ca or strokebestpractices.ca