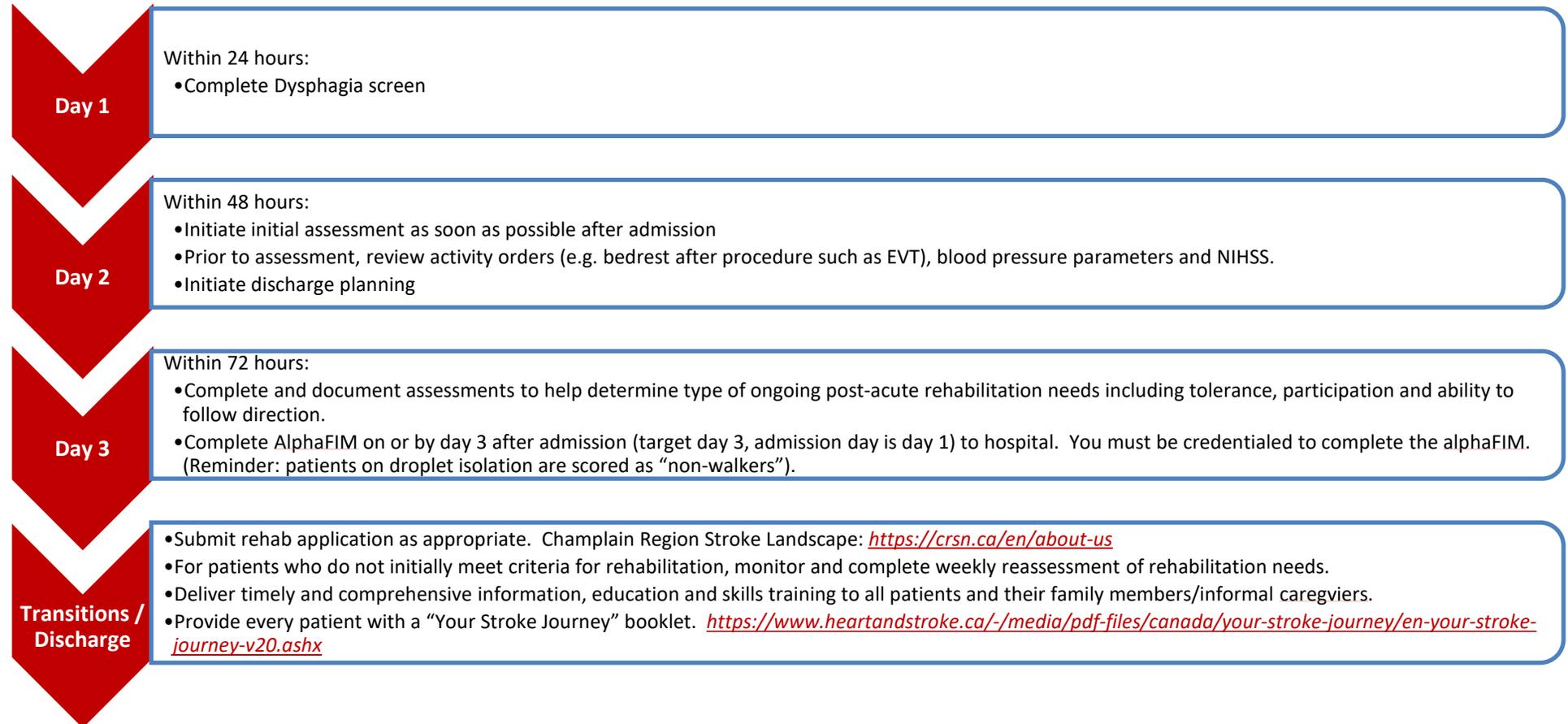


BACKGROUND: To protect staff, facilitate infectious disease evaluations, and conserve PPE, many hospitals have made the decision to admit all COVID-19 positive patients to specialized COVID-19 units. Many of the staff on these units will not have stroke care training. Stroke guidance documents for stroke best practices have been developed to support social workers unfamiliar with managing acute ischemic and hemorrhagic stroke patients. This information is intended to be “guidance rather than directive” and is not meant to replace clinical judgment.

Acute Stroke Care Timelines (CSBPR, 2018)



This document is meant to support staff who may not have experience working with the acute stroke population and provides a summary of the typical process and resources required to support patients admitted to hospital following stroke.

Visit the CRSN website for more information: www.crsn.ca

- To learn more on post stroke conditions and to access practice tools: <https://crsn.ca/en/clinical-tools-resources>
- For all patient handouts/infographics: <https://crsn.ca/en/resources-for-stroke-care-and-recovery>

Topic	Key Messages	Where to Find More Information
Assessment	<p>Complete full psychosocial assessment as soon as possible after admission.</p> <ul style="list-style-type: none"> • Provide ‘Your Stroke Journey’ booklet to patient. Send link of booklet to family by email if possible. • Patients and their families should be provided with information about peer support groups in their community where available, descriptions of the services and benefits they offer, and be encouraged to consider participation. This can be found in ‘Stroke Journey Booklet’ and on CRSN website. 	<p>Your Stroke Journey</p> <p>CRSN- Stroke Survivor and Caregiver Support</p>
Mood and Emotions Post-Stroke	<p>Complete ‘PHQ-9 Depression Questionnaire’ upon admission.</p> <ul style="list-style-type: none"> • All patients who have experienced a stroke should be screened for post-stroke depression, if deemed medically appropriate, given the high prevalence of post-stroke depression. A patient’s whose screening indicates a high risk for depression should be assessed in a timely manner by a healthcare professional. • It is important to provide psycho-education surrounding post-stroke depression to patients and families and for a patient’s mental health to be monitored throughout the continuum of stroke care. 	<p>PHQ-9 Screen</p> <p>Emotions and Mood Post Stroke</p>
Education and Self-Management	<p>All patient’s, families, and informal caregivers should receive timely, comprehensive information, education, and skills training by all team members.</p> <p>Examples for SW include: education around coping, supports, financial resources, and advanced care planning, as appropriate. Please see link attached for comprehensive list.</p>	<p>Education and Self-Management Checklist</p>
Transitions	<p>1. <u>Referring to In-Patient Rehab:</u> Once a patient’s AlphaFIM (AF) is completed on Day 3:</p> <ul style="list-style-type: none"> • If AF is in the range of 40-89 AND the patient is medically stable AND meets all rehab criteria - send inpatient rehab referral to appropriate program. • For patients who are not medically stable or do not initially meet criteria for rehabilitation, weekly reassessment of rehabilitation needs may be considered during the first month, and at intervals as indicated by their health status thereafter. Social work to continue to liaise 	<p>Rehab Criteria</p> <p>Rehab Locations (inpatient and outpatient) and Referral Process for TOH</p>

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	<p>with multidisciplinary team re: patient’s status and progress – and to apply to rehabilitation as appropriate.</p> <ul style="list-style-type: none"> • Please note, the AF score is used to help guide decisions around rehabilitation. Clinical judgement and ongoing assessments from multidisciplinary team monitoring potential progress should be considered when making decision around rehab readiness and place of care. <p>2. <u>Referring to Out-Patient or Community Rehab:</u> If AF is >80 AND the patient requires SLP/OT/PT follow-up send referral to outpatient or Community rehab program based on geographic location or patient needs:</p> <ul style="list-style-type: none"> • Ottawa: Bruyere Continuing Care Ambulatory Stroke Rehabilitation Clinic and Physiatry <ul style="list-style-type: none"> ○ Fast Track referral used to access Rehab and/or Physiatry services • Community Stroke Rehabilitation (AF >79) <ul style="list-style-type: none"> - Submit LHIN referral requesting ‘Community Stroke Therapy’. Attach all relevant therapy assessments and discharge summaries with referral. - See the referral pathway algorithm to help your team select between OP services at Bruyere or CSR services. • Perth Hospital <ul style="list-style-type: none"> - Via direct consult with Dr. Stolee (1-613-267-1500 x2252) <p>3. <u>Patient has been admitted to your facility awaiting bed at Inpatient Stroke Rehab:</u></p> <ul style="list-style-type: none"> • It is strongly recommended that this rehab plan be followed. • Any changes to the rehab plan should be made with the input of all Allied Health professions’ (i.e. SLP, PT, OT, SW). <p>If all disciplines are not available at your facility to re-assess rehabilitation needs, then, initial rehabilitation plan should be followed.</p>	<p>Bruyere Fast Track Referral</p> <ul style="list-style-type: none"> - Currently, physiatrists are doing phone or video initial assessments for Fast Track. There is currently NO outpatient therapy being provided. <p><u>Areas served by Community Stroke Rehab:</u></p> <p>Ottawa (within municipal boundaries)</p> <p>United Counties of Stormont, Dundas & Glengarry counties and Akwesasne</p> <p>United Counties of Prescott & Russell.</p> <p>Renfrew County</p>
<p>Palliative and End of Life Care</p>	<ul style="list-style-type: none"> • Social Work may be involved with patients, families and informal caregivers with management of anxiety and depression, and preferred location of palliative care. • Supportive counselling, funeral supports, and bereavement resources should also be provided to families and caregivers as needed. 	

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| | <ul style="list-style-type: none">• Patients, families, and the health care team should have access to palliative care specialists, particularly for consultation regarding patients with difficult-to-control symptoms, complex or conflicted end-of-life decision making, or complex psycho-social family issues | |
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Contact Laura Dunn at the Champlain Regional Network to be redirected to the necessary contacts.



laudunn@toh.ca



613-798-5555 extension 16153

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