Appendix A

Description of the Waterloo Wellington Community Stroke Program

Waterloo Wellington CCAC Community Stroke Model Description

Eligibility Criteria & Indications for Pathway Use

☑ New diagnosis of stroke

☑ Destination of home, being discharged a Waterloo Wellington Hospital

☑ Ongoing rehabilitation goals indicate need for specialized multi-disciplinary stroke services.

☑ Patient is willing to participate in rehabilitation

☑ Patient is categorized as Band 2, 3 4 according to Waterloo Wellington Stroke Banding Model;

AND

☑ Patient functional status is such that their stroke rehabilitation needs are best met in-home rather than an outpatient rehabilitation program;

AND/OR

☑ Patient lives more than 30 minutes away from an outpatient rehabilitation program.

Exclusion Criteria & Indications for Out-Patient Therapy or CCAC Time-Limited Therapy Services

☒ Patient who is functionally independent

☒ Patient whose stroke rehabilitation needs can be managed through an outpatient rehabilitation program or other community support programs (Day Programs, Secondary Stroke Prevention).

☒ Patient with therapy needs that are discrete (e.g., home safety assessment; swallowing assessment). *CCAC therapy services may be considered for specific needs that cannot be met by an outpatient rehabilitation program.*

☒ Patients who are being discharged from hospitals and in-patient rehabilitation sites outside of WW LHIN. Patients who reside outside of WW LHIN region or who reside in long-term care.

Guiding Principles

- The goal of the Community Stroke Model is community reintegration.

- The Care Coordinator is responsible for determining client eligibility for the Community Stroke Model.

- A client's individual rehabilitation needs will determine those services authorized within the service pathway. The services authorized will be determined by the Care Coordinator in collaboration with the hospital stroke rehabilitation team and the Community Therapist. ***The Ontario Stroke Network suggests that 100% of clients will require OT and PT; and 50% will require SLP services upon discharge from acute care or in-patient rehabilitation.***[1]

- A client's individual achievement of clinical outcomes will guide his/her movement along the pathway.

- Collaborative care planning across disciplines (including the Care Coordinator) is crucial to successful care delivery.

- The CCAC Care Coordinator is responsible for communicating detailed information and collaborating with health care providers about care needs from one transition point to the next.

- The CCAC Care Coordinator will act as a system navigator supporting the individual and family/loved ones across the continuum of care from prevention/health promotion through to community reengagement and palliation. Consistency and continuity facilitates transitions and supports the most effective use of resources including optimizing linkages across the care continuum, and across the health and social service/support sectors.

- Health care professionals will use common assessments across the continuum where possible (i.e. as inpatients and in the community).

- Information regarding assessment/treatment plans/goals/ results will be shared across transitions.

- Results of assessments completed as an inpatient will be used where appropriate to direct treatment by community providers, avoiding unnecessary duplication of assessment. Community providers will reassess upon discharge to obtain measures of client outcomes. Assessment time will be minimized to allow rehabilitation professionals to maximize time spent providing therapy.

- Healthcare providers will work as an inter-professional team to maximize client outcomes.

- Clients will be connected with outpatient and/or community based rehabilitation services to continue progress toward functional goals at time of discharge from the pathway.

[1] The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario. Ontario Stroke Network. 2012.

Components of WWCCAC Clinical Stroke Pathway

Designated Stroke Care Coordinator (CC)					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
		Initial	**Interim**		**Transition / Pre-Discharge**
Interventions	**CCAC Designated Stroke Hospital CC** • RAI-CA completed. • Confirm AlphaFIM® (if acute) FIM® (if rehab) completion (FIM to be completed by hospital team) • Investigate need for inpatient rehab care • Assess client/caregiver concerns about returning home and provide support in transitioning to home • Set date for CCAC/ hospital Discharge Link meeting to discuss rehab goals and plan for transition to the community – ensure invitation to service provider organization for involvement of community OT[1]	**CCAC Designated Stroke Community CC** • Contact client within 72 hours of return home[2] • Complete RAI-HC. • Assess and identify client specific stroke risk factors (e.g. medication compliance/home safety), assess readiness for client change & engage in self-management techniques • Provide client/caregiver with education to support planning to minimize risk and manage crises • Liaise with primary care provider (e.g. physician, NP), or FHT/community pharmacy as required • Confirm referral status for community supports/resources (as	• Continue to facilitate referrals to community supports/resources & address any access to services/ care barriers • Ensure information sharing of client's overall status and care needs with circle of care • Investigate client progress, goal attainment and evaluate outcomes expected to be achieved within first month of returning home; • Coordinate and chair inter-professional care conference at 3 weeks post-discharge[3] • Re-assessment and evaluation of overall client care plan (i.e. service plan)	• Liaise with service providers and community supports for updates on service specific goal attainment and outcome evaluation. • Update client overall care plan in accordance with outcomes and goal attainment (i.e. service plan) • Consider transition to community independence • Re-assess at regular intervals to assess for readiness for rehab in alternate care setting (e.g. outpatient services, congregate care) • Follow up on referral(s), as appropriate: o Outpatient / Day Rehab programs as	• Follow CCM client services standards of care by population • Coordinate and chair care teleconference with "Lead therapist" (week 10-12)[4] • Investigate client progress, goal attainment and outcome evaluation • Update client overall care plan in accordance with outcomes and goal attainment (i.e. service plan) • Establish discharge/transition plan in coordination with client, family and team • Follow up on any outstanding referral(s), as appropriate:

[1] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care 4th Edition, 2012-2013 Update: Recommendation 6.1

[2] Client Services Standards of Care by population, PCSC June 2011

[3] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4

[4] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4

	• Discharge Link meeting • Arrange for OT pre-discharge assessment if needed (should occur close to discharge date) • Develop overall client care plan (i.e. discharge service plan including nursing and PSW) with client, caregiver and healthcare providers, as appropriate • Initiate services/equipment ordering as per CCAC policies & procedures • Initiate referral to community resources, as required • Initiate referral to primary care as necessary (possible Care Connector role)	applicable and available): o Stroke specific peer support and education programs o Fall prevention programs o Respite resources – in-home, adult day programs, short stay respite (facility based), private pay resources • Develop strategies to facilitate community re-engagement • Refer to appropriate CCAC services based upon risk assessment	• Review key outputs from RAI assessment • Follow up on any identified caregiver issues	need indicates appropriate o Other community supports	o Outpatient[5] / Day Rehab programs as need indicates appropriate o Other community supports • Discharge from pathway • Evaluate need for ongoing service beyond pathway

[5] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4

Designated Stroke Care Coordinator Care Coordinator					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
		Initial	**Interim**		**Transition / Pre-Discharge**
Expected Outcomes	**For clients ready & eligible for care at home** **1)** Clients, families and caregivers have been assessed to determine their home and community care needs and readiness for information and education, training, psychosocial support, and health and social services[6]; **2)** Initial overall client care plan developed; **3)** Links to community agencies to support expected outcomes initiated (self-referral/ by CCAC); **4)** Early supported discharge from hospital for clients with mild to moderate disability post-stroke[7];	**1)** As per CCM Client Services Standards of Care, status of referrals to community resources/programs and primary care will be confirmed[8]; **2)** Client/caregiver will report smooth transition to home from hospital and initiation of home and community care supports; **3)** Client/caregiver will be able to report plan to manage potential risk issues at home and identify strategies to reduce risks; **4)** Client/caregiver will be aware of the purpose of care conferences and the meeting schedule (as required/anticipated) to ensure effective care coordination upon return home; **5)** Changes in clients/caregivers home and community care needs and readiness for information and education, training, psychosocial support, and health and social services will have been determined.[9]	**1)** Client will report needs are addressed by community supports; **2)** Client/caregiver will report feeling supported in the recovery process; **3)** Inter-professional collaboration and clinical information sharing will support client-centered progression along the care pathway; **4)** Client reports rehab needs being met	**1)** Client is progressing to increasing independence and function. **2)** Client will report needs are being addressed by community supports; **3)** Client's care will be coordinated as evidenced by timely sharing of information across care partners	**1)** All identified client barriers to function have been addressed; **2)** Family client will have achieved identified goals & outcomes; **3)** Client/caregiver/family understand relevant discharge information and process for re-engagement with CCAC; **4)** Discharge/Transition plan is communicated to the circle of care; **5)** There is a plan to address or mitigate future potential risks

[6] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care 4th Edition, 2012-2013 Update: Recommendation 6.1

[7] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4

[8] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care 4th Edition, 2012-2013 Update: Recommendation 6.1

[9] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care 4th Edition, 2012-2013 Update: Recommendation 6.1

Occupational Therapy ***Overall Outcome****: Client will live safely at home and will achieve maximum independence in ADL/IADL with or without supports (8/16 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week)*[10]					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
		Initial	**Interim**		**Transition / Pre-Discharge**
Interventions	**Hospital Therapist:** • Complete Hospital Rehabilitation Report • Hospital CC in conjunction with hospital therapists recommend whether a pre-discharge home safety assessment is necessary or whether a high priority OT visit is necessary upon client's discharge from hospital. **Community OT:** • Participate in discharge linking meeting • Complete if applicable a pre-discharge, home safety assessment & make recommendations to decrease risks and ensure safe transition home • Feedback to hospital therapists via Hospital CC regarding outcome of home assessment, as applicable. • Provide high level training to client/caregiver/PSW in transfers, positioning/bathing, as appropriate	• Review findings from hospital assessments and determine need for further testing/ evaluation (e.g., FIM, Barthel, Reintegration to Normal Living Index (RNLI)) • Evaluate recommended equipment and home / vehicle modifications • Further assessment of ADL/mobility/arm function needs, as required (OT/PT role) • Provide education regarding the safe use of equipment and adaptive techniques • Follow through with repetitive and novel tasks to challenge the client to acquire necessary motor skills to use the involved limbs during functional activities[11] • Follow up regarding funding applications- ADP, insurance • Facilitate purchase/rental of equipment • Teach adapted methods for task specific activity completion.*motor	• Attend inter-professional case conference at 3 weeks • Continue to teach and modify adapted methods for task specific activity completion (applying *motor learning principles). • Continue with home assessment and modification recommendations, as applicable • Liaise with inter-professional team on clinical plans relevant to mutual client goals • Continued follow up on funding applications • Completion of ADP application, as applicable • Facilitate access to the community for integration and re-engagement purposes	• Evaluate goal attainment and re-adjust plan as required. • Initiate discussion regarding discharge. • finalize funding for equipment and home modification • Link with community resources. • Liaise with other disciplines	• Repeat stroke assessment tools (e.g., FIM, Barthel, RNLI) • Desired outcomes achieved • Liaise with Community CC. • Regarding discharge plan. • Discharge

[10] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4; Ontario Stroke Network, The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario: 2012

[11] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.3

		learning principles • Train client/ caregiver/PSW in skills needed and problem solving for ADL performance • Provide home program for independent practice • Facilitate access to the community for integration and re-engagement purposes • Provide home remediation/compensation therapy program (e.g. ADL/IADL mobility etc.) as appropriate			
Expected Outcomes	**1)** Prior to discharge, if applicable, home safety assessment findings will be shared with CCAC/hospital to support safe transition. **2)** Necessary equipment/home modifications will be identified to the client/family and hospital care team to support safe transition home.	**1)** Completed initial Occupational Therapy assessment & clinical care plan established; **2)** Client/caregiver will demonstrate knowledge and understanding of recommendations made to support safe functioning within his/her environment; **3)** Any additional services or equipment will be identified and recommended to CCAC; **4)** Client/caregiver will demonstrate improved motor skills during functional activities	**1)** Team member will have knowledge of the client's goals and the overall care plan and the role each team member will play in contributing to achievement of the client's overall outcomes; **2)** Client/family will understand the potential safety risks related to condition/situation; **3)** Client/caregiver will be implementing initial client priority recommendations needed to support safe functioning within his/her environment or have an identified plan for implementation; **4)** Client/caregiver will demonstrate improved motor skills during functional activities	**1)** Client demonstrates improved function (with or without adapted methods/ supports) in safely performing ADL; **2)** Client reports satisfaction with level of community integration (with or without supports); **3)** Home/vehicle modifications are in place or a plan is in place and early steps being worked on; **4)** Client/family is aware of and linked with community as appropriate	**1)** Client demonstrates improved function (with or without adapted methods/ supports) in safely performing ADL; **2)** Client reports satisfaction with level of community integration (with or without supports); **3)** Home/vehicle modifications are in place or a plan is in place and early steps being worked on, as applicable; **4)** Client/caregivers have the supports and knowledge in place to be ready for discharge. **5)** CC is fully aware of plan and outstanding issues. **6)** Client/caregiver will have consolidated strategies and suggestions by incorporating into daily living **7)** Improved motor skills during functional activities

Occupational Therapy ***Overall Outcome*****:** *Client will demonstrate optimal cognitive and perceptual function to support safety and meaningful community re-engagement (8/16 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week[12])*					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
Interventions	**Hospital OT:** • Complete Hospital Rehabilitation Report • Hospital OT identifies and completes necessary cognitive and perceptual testing using standardized outcome measures **Community OT:** • Participate in Discharge Link meeting	• Review findings from hospital based assessment and determine need for further assessment • Educate regarding cognitive/ perceptual limitations. • Identify and teach client/caregiver/PSW: adaptive techniques and strategies, use of cueing, safe use of equipment, potential risks • Assist in problem solving around risk mitigation in activities of daily living • Engage in cognitive and perceptual re-training • Assess ability to return to previous functional roles. • Link with community resources relevant to cognitive and perceptual needs/deficits.	• Evaluate goal attainment and re-adjust clinical plan as required. • Liaise with other disciplines and PSWs as required. • Initiate discussion regarding discharge. • Confirm linkages with community supports • Attend inter-professional case conference at 3 weeks	• Monitor client/caregiver's ability to consolidate strategies and suggestions into daily living.	• Repeat stroke assessment tools (e.g., Line Bisection, MOCA) • Desired outcomes achieved • Liaise with Community CC regarding discharge plan. • Discharge.
Expected Outcomes	**1)** Assessment and discharge findings from hospital stay have been communicated to the community OT.	**1)** Client's cognitive / perceptual skills are assessed and the client/caregiver demonstrate an understanding of the impact of cognitive/perceptual deficits on the client's functioning; **2)** Client/caregiver will use (or be knowledgeable about)	**1)** Team member will have knowledge of the client's goals and the overall care plan and the role each team member will play in contributing to achievement of the client's overall outcomes; **2)** Client/caregiver will understand the potential	**1)** Client/caregiver will understand the potential safety risks related to the condition/situation **2)** Caregiver risk issues are communicated to the CCAC CC for follow up.	**1)** Client/caregiver will have consolidated strategies and suggestions by incorporating into daily living. **2)** CCAC CC is aware of plan and any outstanding issues

[12] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4; Ontario Stroke Network, The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario: 2012

		strategies to perform tasks with or without support; **3)** Client/caregiver will be aware of appropriate community resources/programs to support improved independence/quality of life that considers the client's cognitive/perceptual needs;	safety risks related to the condition/situation **3)** Intervention improves the function and quality of life as per client's self-report **4)** Caregiver risk issues are communicated to the CCAC CC for follow up.		

Physiotherapy ***Overall Outcome:*** *Safe mobility and return of motor function (10 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week[13])*					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
Interventions	**Hospital:** • Complete "Hospital Rehabilitation Report" • Complete recommended best practice stroke assessment tools (e.g., Chedoke McMaster Stroke Assessment (CMSA), Berg Balance, Timed up and Go (TUG)) • Teach home exercise program to client • Teach caregiver transfer techniques. • Identify appropriate mobility aid • CC completes community referral for care pathway	• Review findings from hospital based assessment and determine need for further assessment • Assess for safe mobility in the home • Assess for and prescribe equipment, assistive devices, orthotics, home modification • Review/prescribe/ progress home exercise program for strengthening, motor retraining program using motor learning principles, task oriented functional activity[14], gait and balance retraining • Identify potential risk for falls using standardized measure such as Berg Balance Scale and	• If PSW involved in care arrange to teach PSW: exercise program, transfers, ambulation, safe use of equipment, application of adaptive devices, the correct positioning and handling of the affected limb • Evaluate equipment/orthotics • Inter-professional case conference at 3 weeks • Follow up with equipment funding as required	• Evaluate goal attainment and re-adjust plan as required. • Initiate discussion regarding discharge	• Repeat stroke assessment tools (e.g., CMSA, Berg Balance, TUG) • Desired outcomes achieved • Liaise with Community CC • Regarding discharge plan. • Discharge

[13] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4; Ontario Stroke Network, The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario: 2012

[14] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.3

		problem solve to minimize risk • Assess for shoulder pain • Educate regarding correct positioning and handling of affected limb • Train client, caregiver, PSW in skills needed for safe mobility and home exercise program • Assess upper and lower extremity motor recovery • Follow up regarding funding applications- ADP, insurance • Facilitate purchase of equipment • Communicate findings with family and educate re strategies to reduce risk			
Expected Outcomes	**1)** Assessment and discharge findings from hospital stay have been communicated to the community PT.	**1)** Completed initial physiotherapy assessment completed and clinical care plan developed **2)** Client/ caregiver will demonstrate knowledge and understanding of interventions such as: -home exercise program -safe use of mobility and ambulation equipment -understanding of motor learning principles to improve function **3)** Any additional services or equipment will be identified and recommended to CCAC	**1)** Team member will have knowledge of the client's goals and the overall care plan and the role each team member will play in contributing to achievement of the client's overall outcomes; **2)** Client/caregiver will be aware of proper handling techniques to manage shoulder pain and promote functional motor return , as applicable **3)** Client/caregiver will demonstrate safe ambulation/transfer techniques **4)** Shared knowledge will be demonstrated by the partners at the case conference **5)** PSW will demonstrate knowledge of taught tasks	**1)** Client/caregiver has the supports and knowledge in place to be ready for discharge. **2)** CC is fully aware of plan and outstanding issues	**1)** Client/caregiver will have consolidated strategies and suggestions by incorporating into daily living **2)** Client demonstrates increased functioning in home environment **3)** Client has improved quality of life.

Speech-Language Pathology-Swallowing ***Overall Outcome:*** *Prevention of aspiration (6/18 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week[15])*

Registered Dietician-Nutrition ***Overall Outcome:*** *Prevention of aspiration (2/2 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week[16])*

	Pre-Discharge	1-2 weeks	3-4 weeks	5-8 weeks	9-12 weeks
Interventions	**Hospital:** • Complete "Hospital Rehabilitation Report" • Provide client with written instructions regarding food/fluid consistency and swallowing strategies. • Identify unmet goals which have not been completed in the hospital setting (noting re-education is an exclusion to admission to community service) • Provide reports of swallowing assessment and diet recommendations completed in hospital for forwarding to the Community SLP/RD if determined community follow up is needed	• Review findings from hospital based assessment and determine need for further assessment • Assess for safe swallowing and nutritional needs • Identification of clients specific dietary issues (e.g. cultural) • Positioning/ compensatory strategies • Provide education regarding: oral hygiene management, diet/fluid modification (identification of optimal consistency), feeding strategies, risk of aspiration • Ongoing assessment of swallowing • Communicate findings with family and educate re dietary and swallowing strategies to reduce risk • Referrals for video fluoroscopic swallowing assessment as clinically indicated	• Re-assess swallowing at regular intervals and adjust diet as needed • Liaise with other disciplines involved in care. • Explore funding options for supplies • If PSW involved in care teach PSW: adaptive techniques, feeding techniques, positioning • Inter-professional case conference at 3 weeks (SLP only) • Determine ongoing need for clinical intervention	• Liaise with inter-professional team re: attainment of goals. • Evaluate goal attainment and re-adjust plan as required.	• Desired outcomes achieved • Liaise with Community CC regarding discharge plan. • Discharge

[15] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4; Ontario Stroke Network, The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario: 2012

[16] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4

Expected Outcomes	**1)** Client/ families nutritional / feeding requirements will be determined and shared	**1)** Client family will be engaged in and understand strategies to reduce risk of aspiration and optimize client nutritional needs	**1)** Team member will have knowledge of the client's goals and the overall care plan and the role each team member will play in contributing to achievement of the client's overall outcomes; **2)** Support staff/client/caregiver will understand feeding techniques positioning etc. **3)** Client/family will be aware of symptom of heightened risk of choking, aspiration pneumonia, dehydration	**1)** Client/ family will have established links to funding sources **2)** Client family will need be able to identify higher risk situations and have contacts **3)** Clients will maintain required nutritional needs **4)** Support staff will understand feeding techniques, positioning to reduce risk	**1)** Client/ family will have established links to funding sources **2)** Client family will need be able to identify higher risk situations and have contacts to mitigate risks in future **3)** Clients will maintain required nutritional needs **4)** Support staff will understand feeding techniques, positioning to reduce risk

Speech-Language Pathology ***Overall Outcome:*** *Optimal Communication (12/18 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week[17])*					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
Interventions	**Hospital:** • Provide SLP report of assessments/treatment provided in hospital for forwarding to Community SLP • Complete the communication assessment using standardized measures (e.g., Western Aphasia Battery or Boston Diagnostic Aphasia Examination (BDAE); Frenchay Dysarthria Assessment) • Initiate supportive communication or when appropriate, Augmentative	• Review findings from hospital based assessment and determine need for further assessment • Educate client/caregiver regarding the nature of the communication disorder and prognosis for improvement. • Identify and teach client/caregiver / Inter-professional team members strategies to promote a supportive communication approach and effective communication to improve client's	• Identify potential risks in the home situation and assist to problem solve to minimize risks. • Support client in developing functional communication for accessibility and reintegration into social and community activities • Teach client/caregiver use of ACS, where applicable. • Explore funding options for ACS. • Inter-professional case conference at 3 weeks	• Liaise with other disciplines. • Evaluate goal attainment and re-adjust plan as required. • Initiate discussion regarding discharge.	• Repeat the communication assessment using standardized measures (e.g., Western Aphasia Battery/BDAE/Frenchay Dysarthria Assessment) • Desired outcomes achieved • Liaise with Community CC regarding discharge plan. • Discharge

[17] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4; Ontario Stroke Network, The Impact of Moving to Stroke Rehabilitation Best Practices in Ontario: 2012

	Communication System (ACS)	communicative access at home and in community. • Develop a personalized Augmentative Communication System or refer to Augmentative Communication Facility for assessment if appropriate. • Provide and train client/caregiver in home program for independent practice. • Link family/client to any community support agencies such as the Aphasia Institute for ongoing education and support in supportive communication			
Expected Outcomes	**1)** Client/ families communication requirements will be determined and shared with team	**1)** Client family and team members will be engaged in, understand and use strategies to improve communication	**1)** Team member will have knowledge of the client's goals and the overall care plan and the role each team member will play in contributing to achievement of the client's overall outcomes; **2)** Client, family and inter-professional team members will be aware of strategies to improve communication.	**1)** Client/ family will have established links to funding sources **2)** Client family will need be able to identify higher risk situations and have contacts **3)** Client will be able to express needs and understand communication partners using communicative strategies; **4)** Family/caregiver/ communication partners will be able to use strategies to engage in successful communication with client	**1)** Client/ family will have established links to funding sources **2)** Client family will be able to identify higher risk situations and have contacts **3)** Client will continue to consolidate strategies to support ability to communicate needs effectively.

Social Work ***Overall Outcome:*** *Optimal psychosocial functioning (6/6 visits over 12 weeks; combined interdisciplinary intensity of 45 min-3 hrs, 3-5 days per week[18])*					
	Pre-Discharge	**1-2 weeks**	**3-4 weeks**	**5-8 weeks**	**9-12 weeks**
Interventions	**Hospital:** • Initiate health teaching regarding the incidence of depression post stroke • Identify evidence of depression • Initiate education with client and caregiver regarding the impact of stroke and the recovery process. • Provide "Let's Talk about Stroke"/ psycho-educational booklet. • Initiate education regarding secondary stroke prevention.	• Assess coping/depression of client/caregiver (e.g., Caregiver Burden Screen, standardized depression screening tools) • Assist client/caregiver to develop strategies to facilitate coping with impact of stroke and altered mood. • Assist client/caregiver to identify areas of strength, vulnerability, and triggers for altered mood • Educate caregiver regarding the need to balance caregiving and personal health. • Educate regarding: • the incidence of depression • recovery process • community supports, peer supports • self-management • Assist client/caregiver to develop a plan in the event of an emotional crisis or if suicidal ideation present. • Provide supportive counseling and guidance to both client and caregiver as appropriate-including counseling for grief, loss, changing roles. • Assess Client's financial	• Continue with previous interventions as outlined • Link to appropriate community programs or support services to support community re-engagement • Evaluate coping strategies. • Liaise with other disciplines • Refer for intensive therapeutic counseling as required. • Evaluate the effectiveness of coping strategies. • Inter-professional case conference at 3 weeks	• Evaluate goal attainment and re-adjust plan as required. • Monitor participation or withdrawal from social activities. • Initiate discussion regarding discharge. • Evaluate client/caregiver awareness and participation in community resources. • Refer to professional counseling if required.	• Repeat assessment tools to evaluate change in status (e.g., Caregiver Burden Screen, depression scale) • Desired outcomes achieved • Liaise with Community CC regarding discharge plan. • Discharge.

[18] Canadian Stroke Strategy Best Practice Recommendations for Stroke Care: 2012-2013 Update: Recommendation 5.4

		status to determine ability to afford recommended home modifications or equipment • Assist client in compiling the necessary documentation and completing funding assistance applications in order to purchase equipment or complete home modifications. • Assist client to prepare funding requests to community organizations if required. • Assist client/caregiver to identify areas of strength, vulnerability and triggers for altered mood.			
Expected Outcomes	**1)** Client/caregiver will understand the incidence of depression and appropriate management if applicable. **2)** Initiate impact and recovery of stroke as well as prevention education to client and caregiver, providing educational booklet and link to online resources.	**1)** Client/caregiver will understand coping strategies, triggers and develop a plan for crisis for altered mood. **2)** Client/caregiver will be provided with information and support regarding financial assistance and funding applications if applicable. **3)** Client will receive supportive counseling and linkages to community supports if applicable.	**1)** SW will participate in an inter-professional case conference and provide status with respect to SW outcomes. **2)** SW has developed and shared the treatment plan with the client/caregiver including external referrals if applicable	**1)** SW will evaluate established plan and monitor and adjust as appropriate. **2)** Client/caregiver will be aware of discharge plan. **3)** Client/caregiver will have the supports and knowledge in place to be ready for discharge.	**1)** SW will re-evaluate screen and determine if further community supports are required. **2)** SW will liaise with community CC regarding plan and discharge. **3)** Client/caregiver will have consolidated strategies and learning in place.

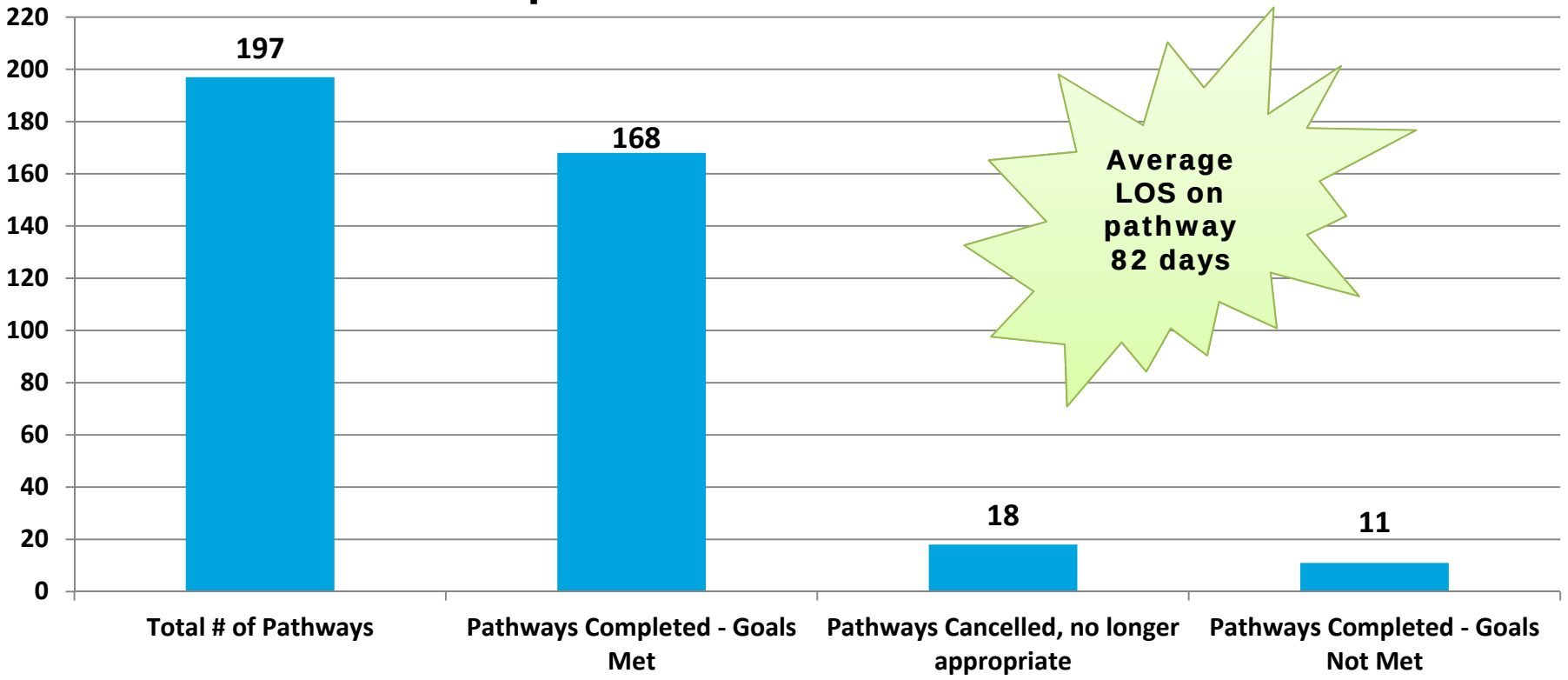
Appendix B

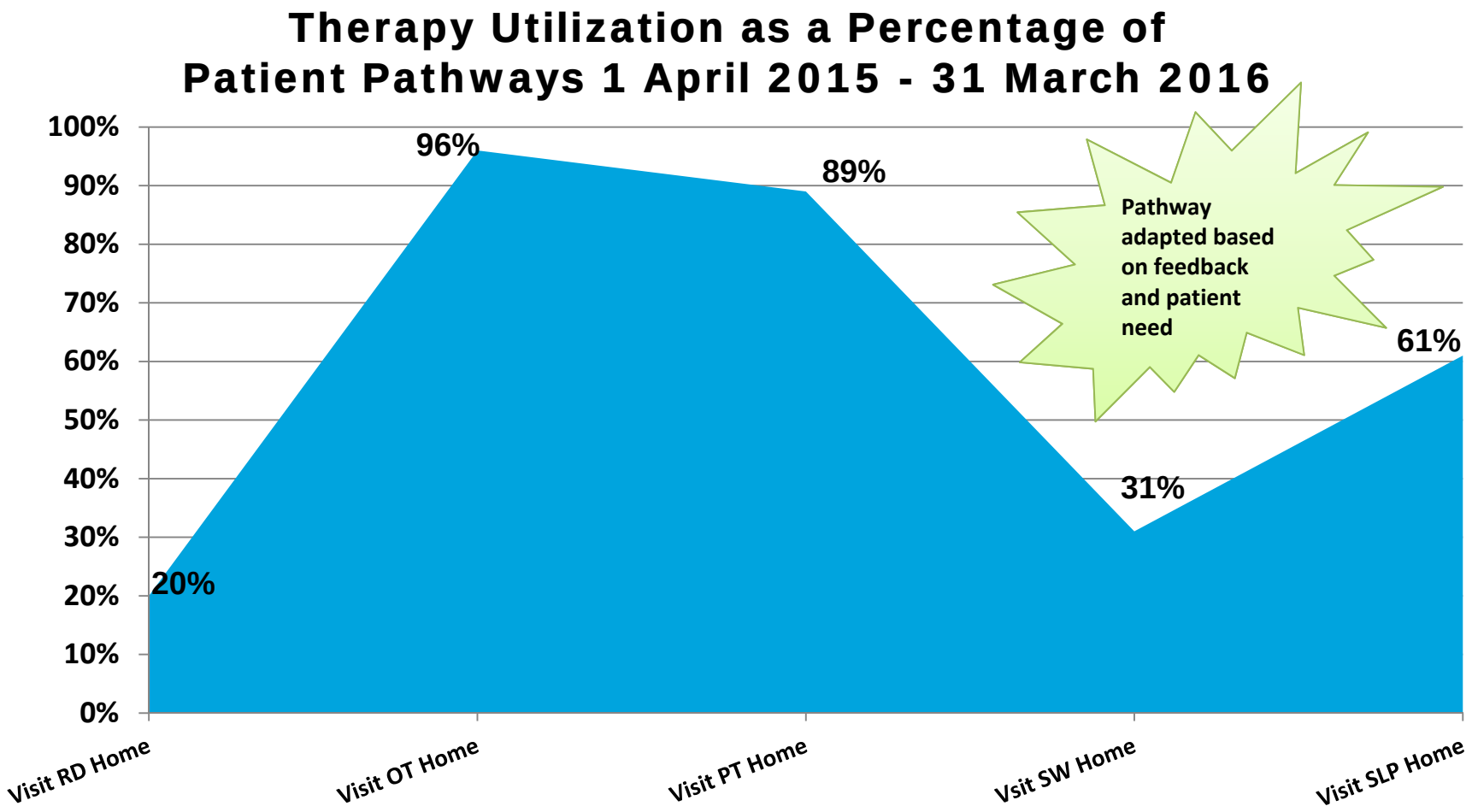
Preliminary Data from the Evaluation of Phase 1 of the

Waterloo Wellington Community Stroke Program

PROGRAM OUTCOMES

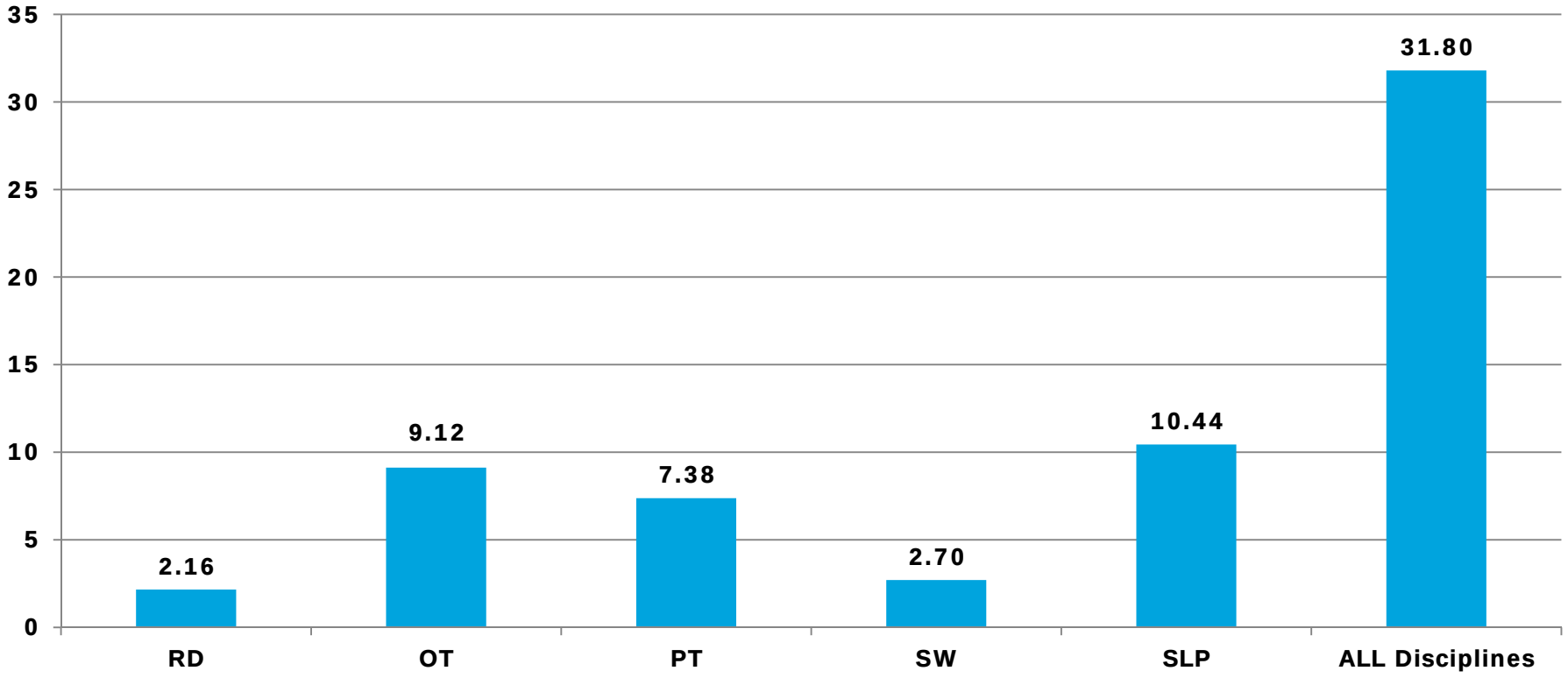
Number of Stroke Pathway Referrals
1 April 2015 - 31 March 2016




Therapy Utilization as a Percentage of Patient Pathways 1 April 2015 - 31 March 2016
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
96%
89%
20%
31%
61%
Pathway adapted based on feedback and patient need
Visit RD Home
Visit OT Home
Visit PT Home
Vsit SW Home
Visit SLP Home

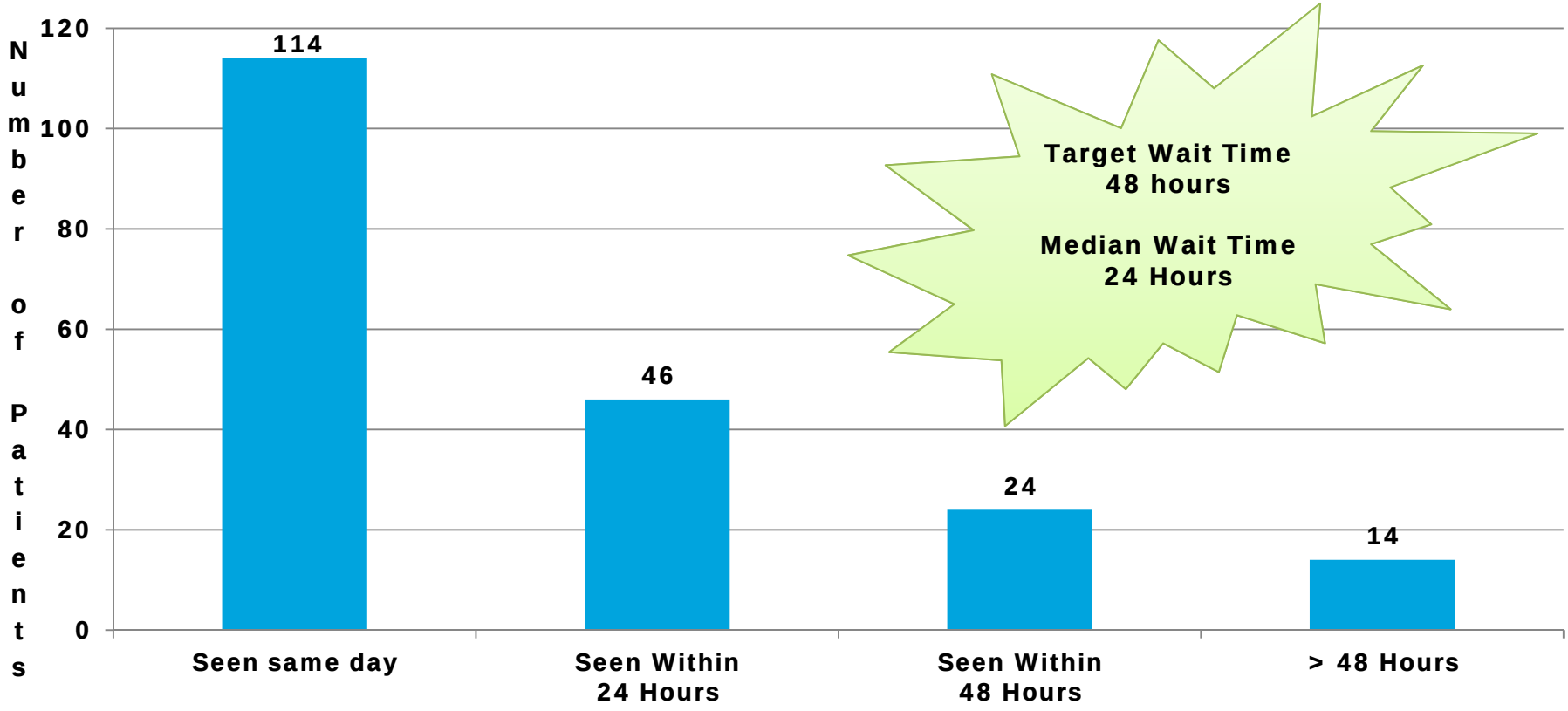
3

Average Visits per Pathway by Discipline
1 April 2015 - 31 March 2016



Initial Therapist Home Visit Wait Times

1 April 2015 - 31 March 2016



PATIENT OUTCOMES

Methods

- Resident Assessment Instrument (RAI)- Home Care (HC)
- Barthel Index (BI)
- Re-integration to Normal Living Index (RNLI)

Data Source

- Assessments performed by program staff
- Statistical analysis

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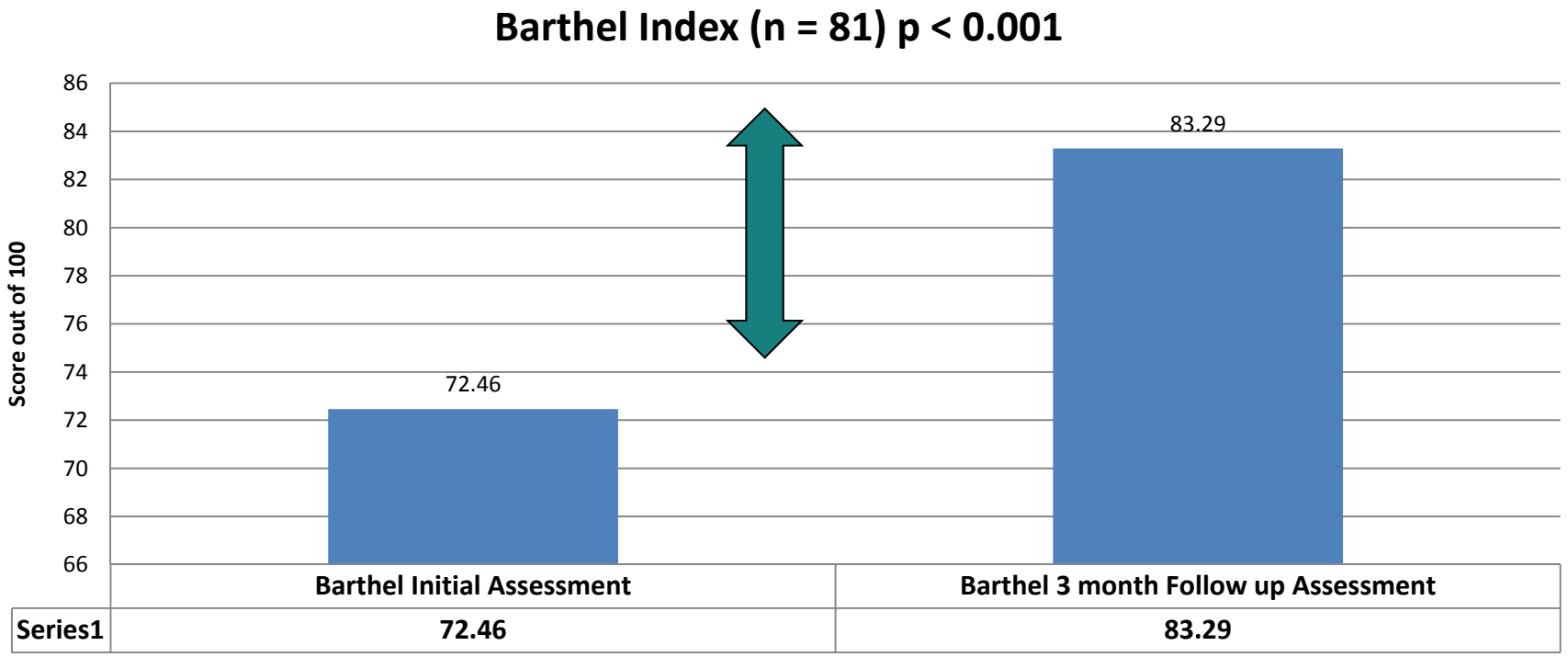
	Patient Outcomes – Stroke Rehabilitation Community Program	
	Functional Outcomes	
1	Barthel Index	
2	Activities of Daily Living (ADL) Short Form	
3	ADL Long Form	
4	ADL Self Performance	
5	Instrumental ADL - Difficulty	
6	Instrumental ADL – Involvement/Dependence	
	Psychosocial Outcomes	
7	Re-integration to Normal Living Index	
8	Depression Rating Scale	
9	Cognitive Performance Scale	
	Health & Quality Outcomes	
10	Frailty and Medical Stability (CHESS)	
11	Client's risk of adverse health outcomes (MAPLe)	
12	Pain	

Functional Outcomes Barthel Index



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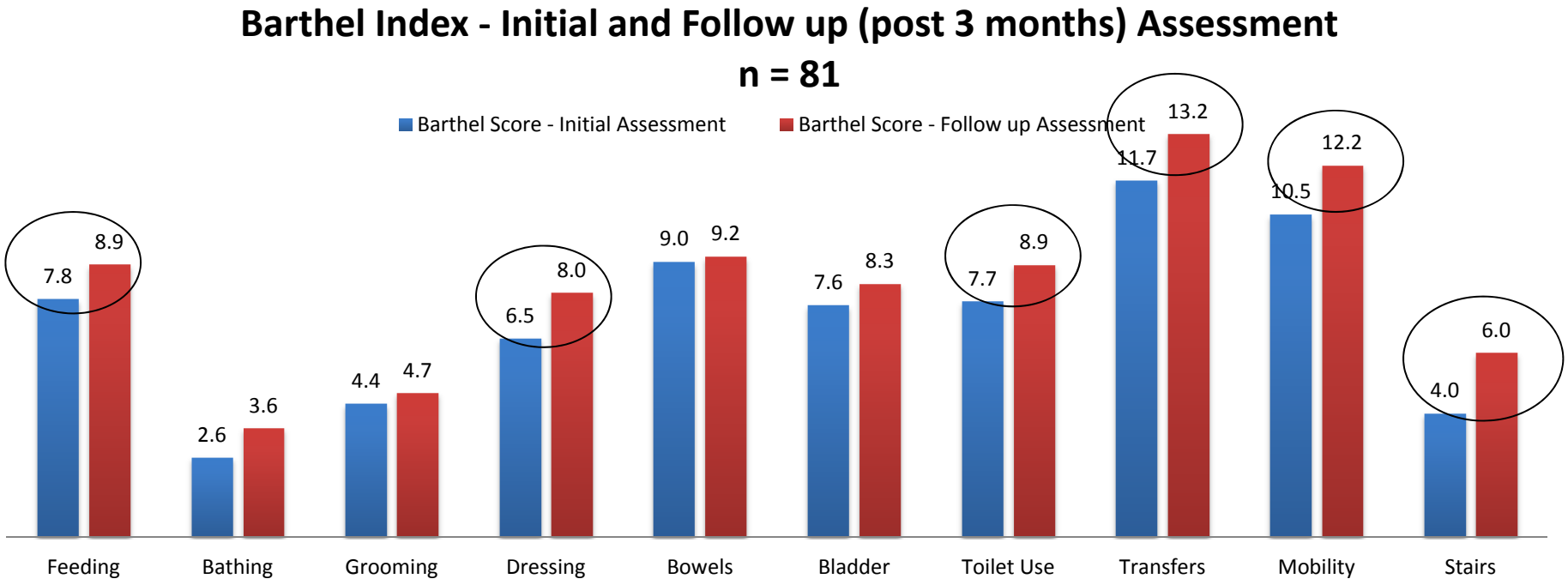
Functional Outcomes Barthel Index



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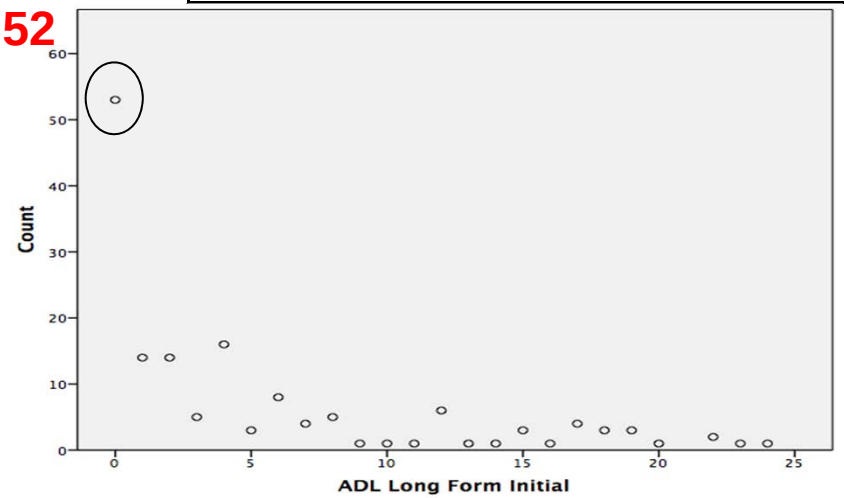
Functional Outcomes ADL – Long Form (0-28)

Statistics				
		ADL Long Form Initial	ADL Long Form Follow up 3 months	Wilcoxon Signed Rank Test
N	Valid	152	147	
	Missing	3	8	
Mean		4.82	3.35	
Median		**2.00**	**0**	**P<0.001**
Mode		0	0	

52



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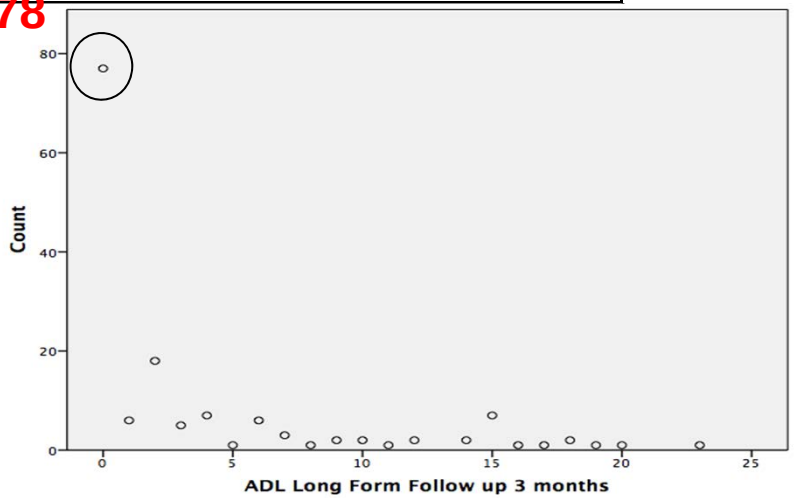
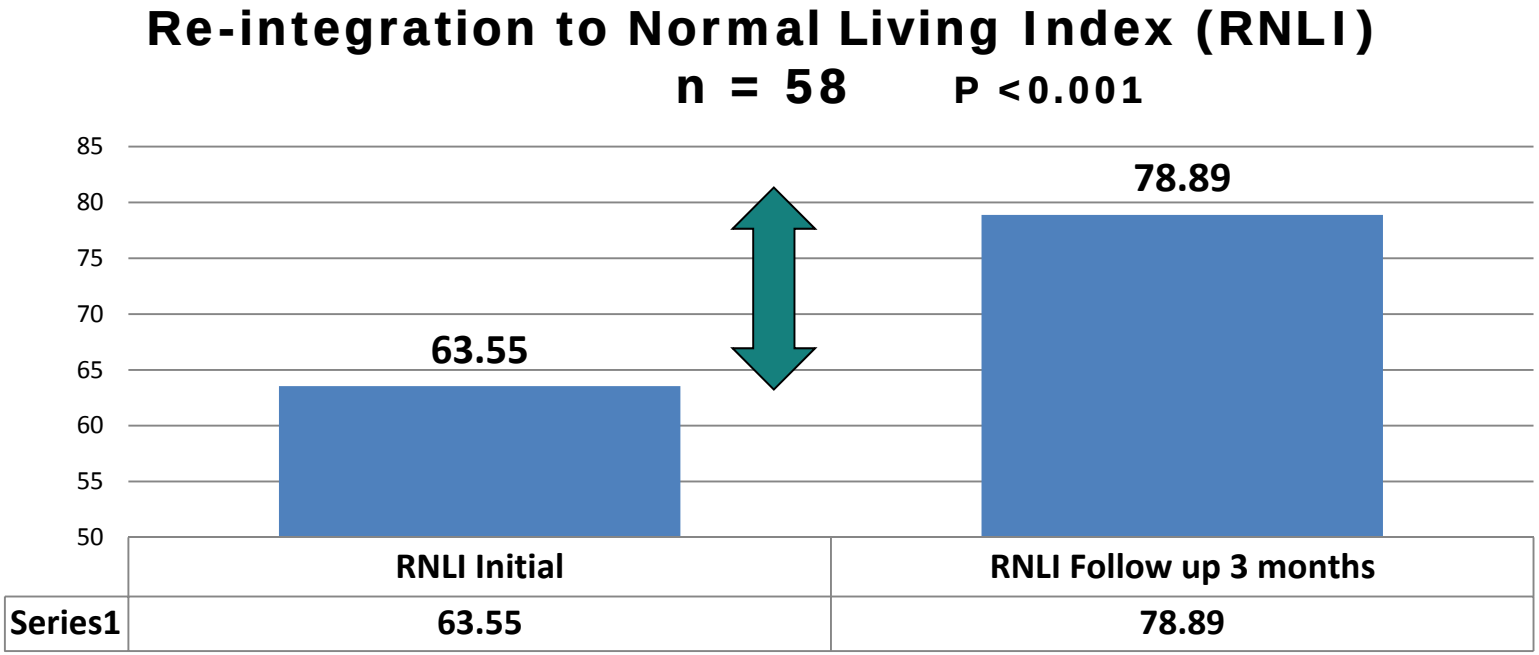


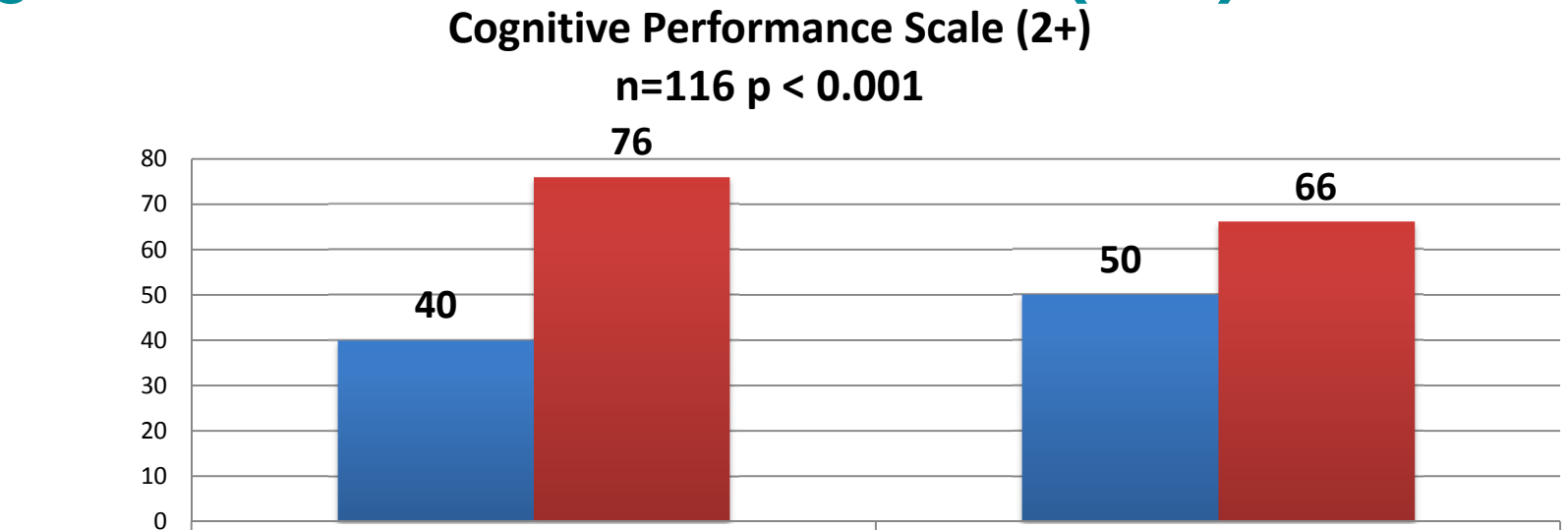
Psychosocial Outcomes

Re-Integration to Normal Living Index (0-100)



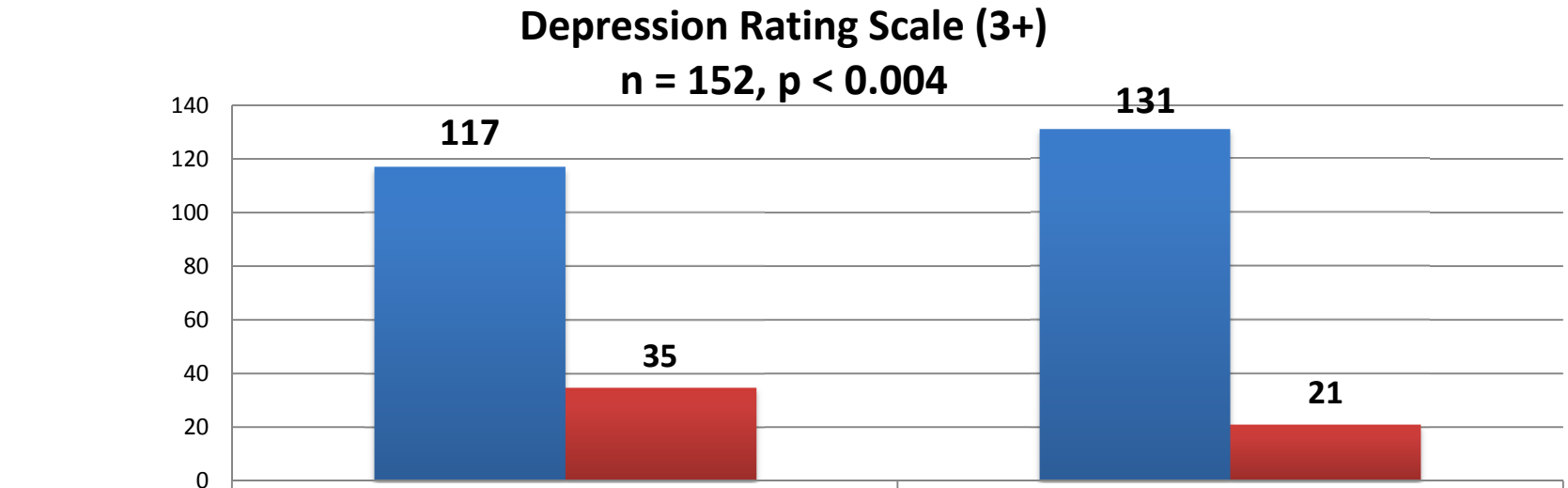
Psychosocial Outcomes

Cognitive Performance Scale 2+ (0-6)



Psychosocial Outcomes

Depression Rating Scale 3+ (0-7)



Conclusion

Results have demonstrated that the CCAC's Stroke Community Rehab Program has improved patient outcomes in the following areas:

1) Functional Outcomes

- Functional Status, Daily Living & Mobility (Barthel & RAI-HC ADL)

2) Psychosocial Outcomes

- Re-integration to Normal Living
- Depression
- Cognition

Accreditation Canada Leading Practice 2014

Limitations

Caution must be used due to:

- Lack of a control group
  - Patients could generally improve over time (even without a program)
  - Planned for Fall 2016 using CIHI data
- Confounding Factors
  - This is a bi-variate analysis
  - Multi-variate analysis (logistic regression) is required to adjust for any confounding factors (e.g. age, stroke severity, etc)
- Sample size - Missing data in follow up assessments

Appendix C

Summary of the ADAPTE workshop

December 15, 2015

[name and address]

Dear ,

On behalf of the Saint Elizabeth Research Centre, Saint Elizabeth, Care Partners and the Waterloo-Wellington CCAC, we would like to thank you once again for attending and participating in the 2-day workshop in late September to help us plan for the second phase of the WWCCAC Community Stroke Program.

In October and the first half of November we reviewed your insights and contributions intently and they were tremendously helpful for putting together a summary of major areas for serious consideration in making changes and improvements in phase 2 of the Community Stroke Program. On November 19, 2015, we reported the proceedings and findings that emerged from the workshops to the Steering Committee for the planning project, and we are pleased to provide you with a copy of the slide deck (see attached) that we reviewed with the Steering Committee, and a bit of a commentary for your further information.

We started by giving the Steering Committee an overview of the two workshop days [slides 3-4], and we reviewed the encouraging words we heard from the group about phase 1 [slide 5]. We also provided the Steering Committee with a listing of the general "worries" (as we called them) that were expressed in the 2-day workshop about phase 2 [slides 6-7]. We confirmed with the Steering Committee that these are exceptionally valuable because they provide a guide to some of the challenges that we will all face in the planning and the implementation of phase 2.

Next, we provided the Steering Committee with the list of the 8 areas for serious consideration that emerged from the discussions for phase 2 [slide 8], as well as a description of the matrix of implementation difficulty vs. benefit that we used on Day 2 [slide 9]. You will see that we created a simplified matrix on the bottom right hand corner for each of the areas we described in more detail [slides 10-17].

We summarized the description of the areas for serious consideration on slides 10-17 and went through these in some detail. The bolded part of the slides represents the ideas or recommendations/ solutions that were offered, and the other part of the slide represents the rationale for the ideas or recommendations/ solutions.

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The reaction of the steering committee to each of these areas was positive overall. For example, when we presented the first idea about training all disciplines on strokes and roles, the committee launched into a discussion of training modules that already exist and could be used, and noted the gaps in what is available, including training on discipline-specific roles. They also liked the idea of a self-assessment tool that could trigger an individual provider's need to "brush up" on their skills or proceed with more in-depth learning on these topics.

As was discussed in the workshop, and as was reflected in the matrix exercise, some of the ideas and some parts of the ideas can be more easily and readily addressed than others. The steering committee provided some feedback to us in terms of the relative timing or feasibility of each of the ideas and parts of ideas, and we are currently in the process of taking that feedback and integrating it into a high-level plan (see below for more details about this).

Regarding the overall impressions of the workshop you expressed at the end of Day 2, we tried to capture these on slide 18. Overall, we heard strong commitment and dedication from all participants to focus on patient/client needs and to "ignore," to the extent possible, the boundaries between settings and between disciplines, if they get in the way of meeting patient/client needs. As we commented on slide 18, this is likely easier said than done, but we tried to convey to the steering committee your common focus on the patient/client.

On slides 19-22, we asked the steering committee a set of specific questions to guide the next steps in the planning process.

On slide 19, we reflected, we believe, the feelings in the workshop that we should try to see the stroke pathway across all settings (from inpatient to home and community reintegration) rather than seeing the pathway as addressing only the CCAC's home care part of the patient's/client's journey. The steering committee was enthusiastic about the prospect of this, but cautioned that several other groups and institutions would have to be involved in making this a reality. The steering committee thought that the ideas generated in the workshop might provide some guidance to those other groups and institutions. In keeping with the scope of the CCAC's mandate, we will focus on the home care part of the patient's journey but endeavor through the pathway to reach as far as possible into the hospital part and into the community supports part to achieve smooth transitions.

On slide 20, we asked specifically whether the goal was to *add* PSW and nursing to the pathway, or to enable any PSW and nursing services a client is getting to *complement and amplify* the efforts of the therapy-focused pathway. Referring to the 8th area for consideration, "early nursing visit", [slide 17] the steering committee discussed folding nursing and PSW into the pathway; they also were keen to emphasize the role of PSW and nursing as complementing and amplifying what is already in the pathway. Our task in the next stages of the planning is to reflect on the appropriate combination of PSW and nursing visits that will meet the needs of clients within the context of the interdisciplinary stroke care team. Some of the additional data we have asked for from the phase 1 experience [slide 28] will help with this task.

On slide 21, we asked specifically about blending outpatient therapy into the pathway to meet specific the needs of specific patient/client needs and goals. The steering committee discussed the concept and in principle agreed with the idea, and discussed some practical issues that would need to be addressed, including streams and wait lists, geography, etc. We will consider these issues in the high level plan.

On slide 22, we discussed the potential change in language from “discharge” to “transition” and this was warmly received.

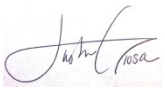
In response to slide 23 where we asked the Steering Committee for any additional observations they had noted about the 8 areas for consideration, there were no specific observations, but the steering committee made it clear that they were very encouraged by the input that you provided. Regarding slide 24 on evaluation of the program, we discussed the Assessment of Interprofessional Team Collaboration Scale (Orchard et al., 2012) that we presented to you and trialed at the workshop. We will be reporting back on this and other possible measures of success in phase 2 in the high level plan. Slides 25-27 were some additional data that were available regarding phase 1, and on slide 28, some other data that we have requested.

On slide 28, we proposed that we would return to the steering committee in December with a high level plan, outlining a possible approach to the elements and implementation for phase 2 of the Community Stroke Program, and we will be seeking the Steering Committee’s input on more detailed issues that we will need to address before finalizing a plan in the new year.

Again, we want to thank you for your keen interest and lively discussions, and look forward to the next steps in 2016.

Yours sincerely,

Paul Holyoke, PhD
Director, Saint Elizabeth Research Centre
paulholyoke@saintelizabeth.com



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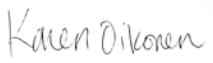

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Review of results of ADAPTE workshop & issues for discussion

WWCCAC Stroke Pathway Steering Committee
Thursday, November 19, 2015, 9:00 – 11:00

1

Overview of today's meeting

1. ADAPTE workshop review – 35 min
   – proceedings
   – overall observations from discussions
   – themes re: recommendations to improve pathway
2. Discussion and feedback – 45 min
3. Updated data from phase 1 – 15 min
4. Establish next steps – 10 min
5. Next meeting date – 5 min

2

Proceedings – Day 1

1. Round Table Introductions
2. Icebreaker Activity
3. Key Ingredients for Integrated Care: Optimal Scope of Practice, OCAR Framework, Continuity of Care
4. Stroke Care Pathway and Roles
5. Defining integrated team roles using OCAR
6. Case Study Applications
7. Summary, wrap up and next steps

3

Proceedings – Day 2

1. Summary of Day 1
2. Early results from phase 1
3. Patient/client perspectives
4. Brainstorming solutions-focused ways to achieve ideas for phase 2
5. Impacts from ideas – what are we looking for?
6. Overcoming challenges
7. Evaluating success in Phase 2
   - Outcomes from care pathway
8. Summary, Wrap Up, Next Steps

4

Summary of Day 1 (1)

1. Stroke pathway (phase 1) is ground-breaking
2. Many successes with phase 1
3. Phase 2 offers opportunity to lead again!
4. Opportunity for front line providers to shape the next phase
5. Adaptations already to pathway

5

Summary of Day 1 (2)

Worries include:

1. Role of unregulated providers
2. Training of PSWs
3. Absence of regulation
4. Relationship/roles of PTA/OTA and PSW
5. Relationships of PSWs with the rest of the team
6. Role of PSW's supervisors
7. Continuity of PSWs
   - May learn from approach to relational continuity for weekend PTs in inpatient rehab

6

Summary of Day 1 (3)

Worries include:

- Training of PSWs may reduce rehab intensity visits
- Pathway not representative of best practice intensity
- Boundaries around disciplines
- Asking/telling versus being told
- Regularity of interdisciplinary discussion

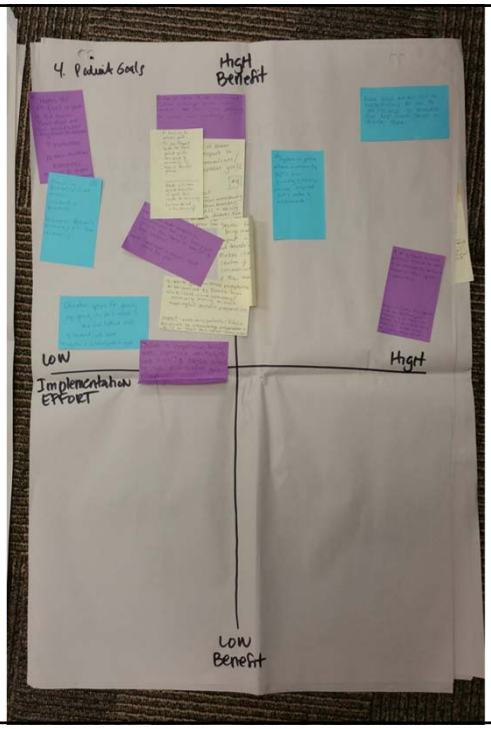
May learn from cardiac program in WW

7

Day 2 – solutions/impacts/challenges

1. Training for all disciplines about stroke and roles
2. Communication platform across settings
3. Flexibility in the pathway
   - More emphasis on RDs' contribution
4. Focus on the patient's/client's goals
5. Complementary, not alternative outpatient and home rehab
6. Designated team
7. Transitions out of the pathway – a continuity and linking meeting
8. Early nursing visit

8



9

Saint Elizabeth RESEARCH CENTRE
Bringing Knowledge to Life

1. Train all disciplines about stroke and roles

- **In-person training days twice per year**
- **Specialized training for PSWs**
- **Online for those who need refresher**
- **All training available to all in regional stroke program (LHIN wide)**
- **Stroke knowledge self-assessment tool**

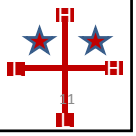
- Greater familiarity all disciplines and their roles
- Greater familiarity with each other and the differences/similarities between settings (acute, inpatient rehab, outpatient and community)

10

2. Communication platform across settings

- **E-platform for documentation and communication across settings**
- ***or* communication book (home only)**
- **"Stroke binder"/stroke passport**
- **Suggestion to test what communication is necessary**

- All know what they need to know
- Fewer assessments, greater familiarity with the person and their situation and care plan



3. Flexibility in the care pathway

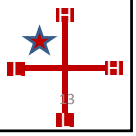
- **Total visits may be the same, but OT lead can change which combination of providers over time is appropriate**
- **Allow/encourage overlap with community services to ease transition off the pathway**
- **Allow some flexibility in length of program**

- "Therapy based on patient goals and needs not just based on a 'bucket of services'"
- Various options for degree of flexibility

4. Focus on the patient's/client's goals

- **Identify patient/client goals, and have all providers work toward those goals**
- **Allow patient/client to adjust visits by various disciplines to fit with their goals**

- Empowers patients/clients
- Provides a focus for interdisciplinary care
- Three-week conference could focus on how to measure progress
- Use Stroke Passport



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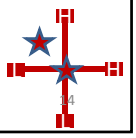
5. Outpatient and in-home rehab

- **Allow outpatient rehab and in-home rehab at the same time**

- Special equipment and setting for outpatient rehab may be clinically beneficial and feasible for some clients even when some parts of pathway provided in-home (and vice versa)
- Pathway should be flexible enough to meet patient rehabilitation/reintegration needs
- Implementation issues: caredove



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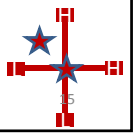
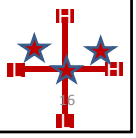
6. Designated team

- **Have a designated team to provide all the stroke care**
- Same providers every time; maybe different teams
  - same individuals increase continuity and trust between team members
- Expertise builds



7. Transitions into and out of pathway

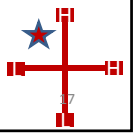
- **Start discussions about transition to the pathway (including outpatient), and then the transition to community supports, early**
- **Hold "Transition meetings", not "discharge" meetings – changing services, not losing them**
- **Front-load therapy to make drop in intensity over time easier to understand/adjust to**
- **Team meeting with family at end of pathway for closure**
- **Consider the whole post-stroke experience a pathway rather than just the CCAC part**



8. Early nursing visit

- **Incorporate nursing at the beginning**
  - **Help prioritize and address other needs of clients that may impede their progress, sort out medications**
- **Another visit 4/8 weeks in to ensure medication is appropriate; identify other issues**

- Medical issues need to be attended to, in addition to rehabilitation



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Solutions/impacts/challenges

- Together with Day 1 observations, the solutions were very helpful for planning for phase 2
- Indicated a high desire to focus on client and "ignore" setting boundaries
  - easier said than done! *but* we have a strong expression of desire to move forward

18

Specific question 1

- Are we committed to making this stroke pathway integrated across settings to achieve a 'single pathway'?
  - as opposed to multiple "hand offs"/ transition points along the way? (e.g. hospital assessment data valued and useful in the community, PT from hospital connecting with PT from community etc.)
    - If yes, how do we support training for providers to understand each other's roles?
    - If yes, how do we achieve a common communication platform across settings?

19

Specific question 2

- What is the goal for adding PSW and Nursing to the stroke pathway?
  - Is it to add additional visits on top of the existing pathway for these two disciplines OR is it to integrate these two disciplines within the existing pathway/visit allowance?

20

Specific question 3

- Can the stroke pathway be blended with outpatient services so that patients can receive treatment from different types of providers in the most appropriate setting to meet their needs?
  - e.g. outpatient PT mixed with pathway OT, nursing and PSW

21

Specific question 4

- Do we want to talk about “discharges” or “transitions”?
  - What do we think about changing the “discharge link meeting” to a “transition meeting” meeting?
  - What about adding a transition meeting near the end of the pathway to link people to community resources?

22

Other observations?

23

Evaluating success

- Assessment of Interprofessional Team Collaboration Scale (Orchard et al, 2012)
  - 37 items
  - three sub-scales: partnership/shared decision-making (19 items), cooperation (11 items) and coordination (7 items)
  - assist health care teams in practice to determine how well they are collaborating in their teamwork

24

Updated data from phase 1

25

Service Utilization
April 1st 2014-Mar 31st 2015

Pathways/Services	Total # of Pathways	Total # of visits
Total stroke pathways completed	160	12277
PSW Utilization		
Combined personal support & housekeeping home	99	7984
Personal Support in IALP neighborhoods	7	419
Nursing Utilization		
Regular Nursing Visits	39	607
Continence	1	1
Rapid Response	9	13
Palliative	2	6

26

PSW Services and Multiple Providers

Service Providers	# of Pathways	# of Visits
Hourly Homemaking - Combined personal support & housekeeping home	99	7984
BAYSHORE HEALTH CARE - WATERLOO	1	53
CarePartners (RC WAT)	18	1437
CarePartners (RC WEL)	26	1377
Closing The Gap Healthcare Group Inc. (HLO)	15	1512
PARAMED HOME HEALTH CARE - WATERLOO	18	1423
PARAMED HOME HEALTH CARE-WELLINGTON	11	1192
REVERA HEALTH SERVICES INC. (PREV. COMCARE WAT)	14	990

27

Updated data

- The number of visits for each type of provider; and the care needs that they had (ADL + for PSW and what for nursing?)
- The number of people discharged from the pathway who continued to have PSW support
- The number of people who had PSW support before they went on the pathway (I presume this would be pre-stroke)
- The number of people on the care pathway who finished before the 12 weeks; the number whose pathway was extended; the number who had rehabilitation therapists attend to their needs after the pathway.
- The cost for people who were discharged from the care pathway - the range, the median, the mean and the total costs.
- Records of any deviation from the care pathway (or, any record of how the ranges of visits were assigned to the various therapies?)

28

Next steps

- Possible planning approach
  - High level outline
  - Identification of implementation issues
  - More detailed plan

29

Next meeting

30

Appendix D

Assessment of Interprofessional Team Collaboration Scale (AITCS)

Assessment of Interprofessional Team Collaboration Scale

Instructions

Note: Several terms are used for the person who is the recipient of health and social services. For the purpose of this assessment, the term 'patient' will be used. While acknowledging other terms such as 'client' 'consumer' and 'service user' are preferred in some disciplines/ jurisdictions.

Please read over each statement and **circle the value** which best reflects how you currently feel your team and you, as a member of the team, work or act within the team.

1	2	3	4	5
Never	Rarely	Occasionally	Most of the time	Always

Section 1: PARTNERSHIP/SHARED DECISION MAKING

When we are working as a **team** all of my team members…..

1	establish agreements on goals for each patient we care for	1	2	3	4	5
2.	are committed to the goals set out by the team	1	2	3	4	5
3	include patients in setting goals for their care	1	2	3	4	5
4	listen to the wishes of their patients when determining the process of care chosen by the team	1	2	3	4	5
5.	meet and discuss patient care on a regular basis	1	2	3	4	5
6.	would agree that there is support from the organization for teamwork	1	2	3	4	5
7.	coordinate health and social services (e.g. financial, occupation, housing, connections with community, spiritual) based upon patient care needs	1	2	3	4	5
8.	use a variety of communication means (e.g. written messages, email, electronic patient records, phone, informal discussion etc.)	1	2	3	4	5
9.	use consistent communication with team members to discuss patient care	1	2	3	4	5
10.	are involved in goal setting for each patient	1	2	3	4	5
11.	listen to and consider other members' voices and opinions/views in regard to deciding on individual care planning processes	1	2	3	4	5
12.	would agree when care decisions are made, the leader strives to obtain consensus on planned processes from all parties	1	2	3	4	5
13.	feel a sense of belonging to the group	1	2	3	4	5
14.	establish deadlines for steps and outcome markers in regards to patient care	1	2	3	4	5
15.	jointly agree to communicate plans for patient care	1	2	3	4	5
16.	consider alternative approaches to achieve shared goals	1	2	3	4	5
17.	encourage each other and patients and their families to use the knowledge and skills that each of us can bring in developing plans of care	1	2	3	4	5
18.	focus of our teamwork is consistently the patient	1	2	3	4	5
19.	work with the patient and his/her relatives in adjusting care plans	1	2	3	4	5

Section 2: COOPERATION

When we are working as a **team** all of my team members…..

20.	share power with each other	1	2	3	4	5
21	help and support each other	1	2	3	4	5
22.	respect and trust each other	1	2	3	4	5
23.	are open and honest with each other	1	2	3	4	5
24.	make changes to their team functioning based on reflective reviews	1	2	3	4	5
25.	strive to achieve mutually satisfying resolution for differences of opinions	1	2	3	4	5
26.	understand the boundaries of what each other can do	1	2	3	4	5
27.	understand that there are shared knowledge and skills between health providers on the team	1	2	3	4	5
28.	exhibit a high priority for gaining insight from patients about their wishes/desires	1	2	3	4	5
29.	create a cooperative atmosphere among the members when addressing patient situations, interventions and goals	1	2	3	4	5
30.	establish a sense of trust among the team members	1	2	3	4	5

Section 3: COORDINATION

When we are working as a **team** all of my team members…..

31.	apply a unique definition of ***Interprofessional collaborative practice*** to the practice setting	1	2	3	4	5
32.	equally divide agreed upon goals amongst the team	1	2	3	4	5
33.	encourage and support open communication, including the patients and their relatives during team meetings	1	2	3	4	5
34.	use an agreed upon process to resolve conflicts	1	2	3	4	5
35.	support the leader for the team varying depending on the needs of our patients	1	2	3	4	5
36.	together select the leader for our team	1	2	3	4	5
37.	openly support inclusion of the patient in our team meetings	1	2	3	4	5

Thank you for completion of this questionnaire!

Appendix E

Evaluation Plan for Phase 1 of the

Waterloo Wellington Community Stroke Plan

Evaluation Question	Data Source	Methods	Sample	Timelines
1. To determine the functional and social outcomes of stroke survivors after completing the stroke rehabilitation community program				
1.1. What are the demographic characteristics of the patients enrolled in the programme?	RAI-HC/CHRIS	Descriptive Statistics Age, Gender, Education, Marital Status Looking at Rehab/Acute	All patients with a RAI-HC assessment	
1.2. What are the clinical characteristics of the patients enrolled in the programme?	RAI-HC/CHRIS/Hospital Data	Descriptive Statistics MAPLE, Cognitive Performance Scale (CPS), CHESS, Pain Scale	All patients with RAI-HC assessment	
1.3. Did the programme improve functional outcomes of patients?	RAI-HC and Barthel Index	Pre and Post Comparison of assessments ADL Long Measure IADL "Involvement/Performance" ADL "Barthel Index" Propensity scores (Comparing outcomes with large cohort of stroke patients)	All patients with RAI-HC and Barthel Index assessment	
1.4. Did the programme improve social outcomes of patients?	RAI-HC and RNLI	Pre and Post Comparison of assessments Depression Rating Scale – RAI-HC Re-Integration to normal Living Index (RNLI) Social CAPS- RAI-HC Propensity scores (Comparing outcomes with large cohort of	All patients with RAI-HC and RNLI assessment	

		stroke patients)		
1.5. Is RAI-HC instrument a useful as a functional outcome measurement tool for rehabilitative care?	RAI-HC and Barthel Index	Correlation Analysis between RAI-HC ADLs and Barthel Index ADLs	All patients with RAI-HC and Barthel Index assessment	
1.6. Is there a difference in outcomes in patients that received consolidated services versus those that did not received consolidated services?	RAI-HC	Comparing RAAI-HC data from pre-April 1st with post-April 1st data		
1.7. What was the impact of providing dietetics services to stroke patients?		Nutrition and Swallowing Section L3 – RAI-HC component C2 and C3 – RAI- HC component		
2. Is the stroke community program able to reduce utilization of acute care resources by stroke survivors enrolled in the programme?				
2.1. What is the percentage of hospital re-admissions made by patients receiving the stroke program?	Hospitals/NACARS	Hospital Re-admission frequency count Within 30 days Within 90 days	All patients enrolled in the programme	
2.2. What is the percentage of unplanned Emergency Department (ED) visits made by patients receiving the stroke program?	Hospitals/NACARS Patient Experience Questionnaire (self-reported)	Hospital ED visit count Reason for ED CTAS	All patients enrolled in the programme	
2.3. Did the stroke community program result in early discharge	Hospital Database	Measuring LOS and comparing them with LOS of other stroke	All patients enrolled in the	

for stroke patients?		patients not receiving the program RPG value defines LOS RPG can tell us what comes to CCAC	programme	
3. To determine whether the inter-professional stroke community team improves the overall patient and caregiver experience during their recovery from stroke at home				
3.1. Did the stroke community program facilitate a smooth transition to home?	Patient Experience Questionnaire Process-based metrics (WWCCAC) Focus Group with team	Count of patients that "strongly agreed or "agreed" to items 1 to 4 on the questionnaire Count of Discharge Link meetings Qualitative data on how discharge link meeting helps the patient	All patients that participated in the questionnaire Program staff that participated in the focus group	
3.2. Did the stroke community program provide timely access to rehabilitative care?	Patient Experience Questionnaire Metric	Count of patients that "strongly agreed or "agreed" to items 5 to 7 on the questionnaire Wait time to first visit	All patients that participated in the questionnaire	
3.3. Did the consolidated (one provider) model improve patient's experience?	Patient Experience Questionnaire Focus Group with team	Count of patients that "strongly agreed or "agreed" to items 8 to 10 on the questionnaire Qualitative data on how team functions, exchanges information, etc.	All patients that participated in the questionnaire Program staff that participated in the focus group	
3.4. Did the program facilitate the return to social activities for stroke patients?	Patient Experience Questionnaire	Count of patients that "strongly agreed or "agreed" to items 13 to 16 on the questionnaire	All patients that participated in the questionnaire	

3.5. Did the stroke community program improve caregiver experience or reduce caregiver distress ?	CareGiver Status – RAI-HC 2 items Focus Group	Focus Group Patient Experience Questionaaire RAI Data (Section G) 2 items related to caregiver distress – G2A and G2C		
4. Are the stroke community teams functioning as originally intended?				
4.1. Are the teams providing visits in a timely manner? (i.e. first visit within 48 hours)	Process-based metrics (WWCCAC)	Average and Median days to first visit (Hospital D/C to first provider visit)	All patients enrolled in the programme	
4.2. Is the stroke community team providing rehabilitative care as per best practice?	Process-based metrics (WWCCAC)	# of patients receiving visits by each provider (e.g. PT/OT/SLP/SW/Diet) Average number of visits by each provider (e.g. PT/OT/SLP/SW/Diet) Percentage number of visits by each provider per discharge pathways Proportion of providers by assistants Average number of visits Case Conferences	All patients enrolled in the programme	
4.3. Percentage of stroke		Discharge Link Meeting		

4.4. Comparison of two providers		Comparing metrics between the two providers		
5. To determine validity and reliability of a patient experience tool for stroke survivors receiving rehabilitative care in community				
5.1. Is the patient experience tool valid for measuring patient experience for stroke patients?	Focus Group with staff Patient Experience Questionnaire	Face Validity Content Validity Construct Validity	All patients that participated in the questionnaire	
5.2. Is the patient experience tool reliable for measuring patient experience for stroke patients?	Patient Experience Questionnaire	Internal Consistency Test-Retest/Inter Observer	All patients that participated in the questionnaire	

Appendix F

Interprofessional Learning Objectives for Stroke Care project

Nursing Self Evaluation Template

http://www.heartandstroke.on.ca/atf/cf/%7B33C6FA68-B56B-4760-ABC6-D85B2D02EE71%7D/Nursing_LO_Self-Evaluation_Template.doc

SELF EVALUATION TEMPLATE
NURSING LEARNING OBJECTIVES FOR STROKE CARE

NAME: _____

*Opportunities for baseline, mid, and final assessments are provided in the self-rating column as recommendation only. Users are encouraged to modify the form and its use to serve their purposes.

Self Rating: Using the rating scale provided below, enter a number that most closely reflects your knowledge/skill/ experience with respect to the learning objectives listed for this Learning Area.

NONE or MINIMAL Knowledge/Skill/Experience			**SOME** Knowledge/Skill/Experience			**EXTENSIVE** Knowledge/Skill/Experience		
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**

LEARNING AREA	**Date**	***SELF-RATING** **Base**	**Mid**	**Final**	**Comments**
Principles of Stroke Care					
There are no nursing learning objectives for Principles of Stroke Care.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Anatomy and Physiology of Stroke					
1. Demonstrates awareness of the penumbra and its significance to functional recovery and factors that influence this area including the impact on neurological presentation.					
2. Demonstrates knowledge of the rationale for the diagnostic tests used in the assessment and management of stroke and incorporates results as appropriate into the plan of care.					
3. Demonstrates knowledge of discipline-specific standardized assessment tools, and the ability to administer the appropriate tools to systematically assess the stroke survivor.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
4. Demonstrates knowledge of the current treatment approaches across the continuum including: ***Pre-hospital Management*** • **E.g., ambulance bypass** ***Prevention*** • **E.g., accessing prevention clinics, risk management** ***ER*** • **E.g., thrombolytics or tPA eligibility, monitoring prior, during and post administration; intraarterial tPA** ***Acute Medical Management*** • **Hypertension (e.g., angiotensin-converting enzyme inhibitors or angiotensin II receptor blocker therapies)** • **Lipid therapy (Statins)** • **Antiplatelet and/or anticoagulants (e.g., Aspirin, Aggrenox, Plavix, Coumadin)** • **Diabetes management** ***Surgical-Interventional Treatment*** • **Carotid endartectomy** • **Carotid stenting and/or thrombolysis** • **Carotid angioplasty.**					
5. Integrates knowledge of the stroke sequelae and potential stroke complications into the plan of care to prevent and/or treat complications.					
6. Demonstrates knowledge of the pathophysiology, clinical presentation and management of secondary stroke complications including: • **Hemorrhagic transformation** • **Reperfusion injury** • **Increased intracranial pressure** • **Cerebral edema** • **Seizures** • **Recurrent stroke.**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Cardiovascular and Respiratory Effects					
1. Demonstrates knowledge of the anatomy and physiology of normal and abnormal cardiovascular and respiratory systems.					
2. Demonstrates the ability to identify signs and symptoms of cardiovascular and respiratory systems complications as a result of a stroke or pre-existing conditions, and an understanding of the management of: • **Deep vein thrombosis and pulmonary embolism** • **Myocardial infarctions** • **Dysphagia and aspiration pneumonia** • **Respiratory status such as airway management/tracheotomy**					
3. Demonstrates the ability to perform a comprehensive assessment of the cardiovascular and respiratory systems including: • **Inspection** • **Palpation** • **Auscultation** • **Vital signs** • **Pulse oximetry** • **Accessory muscle use** • **Breathing patterns** • **Peripheral edema** • **Peripheral pulse** • **Presence of chest pain**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
4. Demonstrates the ability to perform different treatments to manage abnormal breathing mechanisms and patterns including: • **Oxygen therapy** • **Inhaled respiratory therapies** • **Oral, nasopharyngeal airways, tracheostomies** • **Secretion clearance** • **Bronchial hygiene**					
5. Demonstrates knowledge of and the ability to perform airway management and cardiac support according to Basic Cardiac Life Support guidelines.					
6. Demonstrates the ability to assess patterns of breathing during sleep (e.g., sleep apnea, other abnormal patterns of breathing), and communicate for appropriate referral.					
7. Demonstrates the ability to perform methods of monitoring continuous trending of SpO_2/CO_2, pulse (sleep, activity, exercise), and report findings to a physician for appropriate intervention.					
8. Demonstrates knowledge of the effect of medication on the respiratory system and performs assessments to determine the impact of the medication (e.g., pulmonary function tests, peak flows, etc.)					
9. Demonstrates the ability to educate the stroke survivor and caregiver about cardiovascular and respiratory status and management.					
10. Collaborates with the respiratory therapist and/or designated team members to implement strategies and evaluate the effectiveness of interventions.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Psychosocial Effects					
1. **Demonstrates the ability to assess the stroke survivor's reaction to the stroke that may affect coping:** • **Level of participation and engagement in activities such as self care, productivity and leisure** • **Self-destructive behaviours** • **Quality of stroke survivor and caregiver support systems** • **Stability of the stroke survivor's physical condition and presence of pain.**					
2. **Demonstrates the ability to identify and maximize the factors that influence effective coping in the stroke survivor and caregiver.**					
3. **Demonstrates the ability to identify adaptive and maladaptive behaviours in the coping response of the stroke survivor and caregiver.**					
4. **Demonstrates the ability to adjust assessment and treatment sessions to facilitate participation of the stroke survivor and caregiver, given that their coping strategies and reactions may vary.**					
5. **Demonstrates the ability to recognize the signs and symptoms of anxiety, depression and self-destructive behaviour.**					
6. **Demonstrates the ability to administer and interpret standardized and non-standardized depression screening tools independently or in conjunction with other team members.**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
7. Demonstrates the ability to assess for the effects of certain medication or side effects of medications and other medical conditions beside stroke that can affect mood and behaviour.					
8. Demonstrates knowledge of the treatment modalities related to altered psychosocial status: • **Pharmacological agents (e.g., psychotropic medications and potential side effects).** • **Non-pharmacological agents.**					
9. Demonstrates the ability to determine the stroke survivor and caregiver's understanding of the effects of stroke, and their learning needs					
10. Demonstrates the ability to tailor the plan of care and education to meet the coping o needs of the stroke survivor and caregiver.					
11. Demonstrates the ability to assess the stroke survivor's perception of and need for control, and incorporate this into the plan of care.					
12. Recognizes various psychosocial issues that occur following stroke, and adjusts assessment and treatment strategies accordingly to meet the individual needs of the stroke survivor and caregiver.					
13. Demonstrates knowledge of how the psychosocial effects of stroke can affect self-care, productivity and leisure.					
14. Demonstrates knowledge of the social implications of illness (e.g., financial issues, effects on roles).					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
15. Demonstrates the ability to identify and maximize the stroke survivor's and caregiver's coping strengths and sources of hope.					
16. Demonstrates the ability to determine stroke survivor and caregiver social supports and the need for further support, and assists them in accessing these services.					
17. Demonstrates knowledge of the support systems available within and outside the organization for stroke survivors and caregivers.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Communication					
1. Demonstrates the ability to screen for communication disorders including the stroke survivor's: • **Ability to read, write and understand language.** • **Level of education.** • **Autonomic speech, auditory comprehension, comprehension of written language, expressive ability.** • **Dysarthia.**					
2. Collaborates with speech-language pathology and/or designated team members to implement and provide feedback regarding communications strategies and/or devices.					
3. Demonstrates the ability to use alternative communication strategies and/or devices as recommended by speech-language pathology.					
4. Demonstrates the ability to support the stroke survivor and caregiver during the learning phase of implementing alternative communication strategies and devices as prescribed by speech-language pathology.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Independence in Mobility And Prevention Of Complications Of Immobility					
1. Demonstrates knowledge of the rationale and indicators for selecting different transfer approaches and techniques (e.g., 1 or 2 man pivot, independent mechanical lift).					
2. Demonstrates knowledge of the rationale and indicators for selecting correct walking aids (e.g., Quad cane, walker) and assistive devices (e.g., splints, slings, assistive feeding devices).					
3. Demonstrates awareness of the rationale and indicators for selecting appropriate wheelchairs, and seating and positioning equipment.					
4. Collaborates with the team, depending on the environment/situation, and uses: • **Proper handling techniques during transfers, positioning and application of assistive devices (e.g., splints, slings).** • **Proper positioning of the stroke survivor.** • **Proper and safe transfer of the stroke survivor using the appropriate transfer approach or technique.** • **Proper and safe mobilization of the stroke survivor using walking aids and specific strategies.**					
5. Demonstrates knowledge of prevention strategies, and the assessment, management and evaluation of potential stroke-related physical complications (e.g., muscle weakness, paralysis, changes in muscle tone and contractures, loss of balance and coordination,, hemiperetic shoulder and other joint injuries).					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
6. Collaborates with physiotherapy and/or team members to implement and evaluate a comprehensive plan of care.					
7. Demonstrates the ability to educate the stroke survivor and caregiver about: • **Maximizing safety and independence in mobility.** • **Positioning.** • **Prevention and management of physical complications (e.g., arm and hand, foot and ankle).**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Routine Activities of Daily Living (ADL)					
1. Demonstrates the ability to use standardized and non-standardized screening tools – such as Barthel, Mini Mental Status Exam, verbal fluency, line dissection, and apraxia – to determine the physical, cognitive and perceptual abilities that are required to perform ADLs independently or in collaboration with other team members.					
2. Demonstrates knowledge of functional treatment techniques and their importance in helping stroke survivors perform ADLs (e.g., cueing, prompting, hand-over-hand techniques, set up, positioning), and incorporates these strategies when helping the stroke survivor perform ADLs.					
3. Uses appropriate assistive devices when helping stroke survivors perform ADLs.					
4. Demonstrates knowledge of common physical, cognitive, perceptual, visual, sensory, language and behavioural deficits that may impact the stroke survivor's awareness and performance of his/her ADLs, and incorporates management strategies into the care of the stroke survivor.					
5. Collaborates with occupational therapy and/or other team members to implement and evaluate a comprehensive plan of care.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Instrumental Activities of Daily Living (IADL)					
1. Demonstrates awareness of the assistive devices to promote safety and independence at home.					
2. Demonstrates the ability to address safety issues related to independent medication administration as a result of the stroke, as soon as the stroke survivor's condition allows, including: • **Knowledge and rationale** • **Physical ability (e.g. finger dexterity and coordination)** • **Cognitive and perceptual ability** • **Financial resources**					
3. Demonstrates the ability to educate and support the stroke survivor and caregiver on the altered ability to complete IADLs, in consultation with other team members as required.					
4. Demonstrates the ability to educate the stroke survivor and caregiver on the use of assistive devices, strategies and services.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Cognitive, Perceptual and Behavioural Changes Following Stroke					
1. Demonstrates the ability to screen for changes in cognition, perception and behaviour, recognizes altered behaviours, and makes referrals to appropriate team members.					
2. Demonstrates the ability to consider possible causes for cognitive, perceptual and behavioural changes such as a new neurological event, pre-existing condition, current medical condition, and pharmacology.					
3. Demonstrates the ability to implement management strategies used with stroke survivors who demonstrate cognitive, perceptual and behavioural changes following stroke.					
4. Collaborates with team members to implement and evaluate a comprehensive plan of care.					
5. Demonstrates knowledge of the response to medications and side effects that may alter cognition, perception and behaviour, and responds appropriately.					
6. Demonstrates the ability to educate caregivers about cognitive, perceptual and behavioural changes, in collaboration with the team, and how to manage these changes.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Sexuality					
1. Demonstrates that ability to screen stroke survivors/partner for sexual concerns to determine the need for further assessment and intervention by another health care team member.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Nutrition					
1. Demonstrates the ability to identify, manage and evaluate the symptoms of dehydration and malnutrition after a stroke.					
2. Demonstrates knowledge of and the ability to manage various alternative-feeding methods used with stroke survivors (e.g., tube feeding, total parenteral nutrition).					
3. Demonstrates knowledge of the effects of pharmacotherapy on alternate methods of feeding (e.g. enteral feeding interfering with medication absorption).					
4. Demonstrates the ability to support the stroke survivor and caregiver in decision-making about tube feeding.					
5. Collaborates with dietetics to implement and evaluate a comprehensive plan of care.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Dysphagia					
1. Demonstrates the knowledge that all stroke survivors should be kept nil per os (NPO) until a simple, valid, bedside testing screening protocol can be completed.					
2. Demonstrates the ability to recognize the early signs and symptoms of dysphagia including: • **Abnormal tongue movement** • **Wet voice quality** • **Reduced sensation at posterior pharyngeal wall.**					
3. Demonstrates the ability to perform a swallowing screen using a standardized tool including: • **Assessment of alertness and ability to participate in screening** • **Direct observation of the signs and symptoms of oropharyngeal swallowing difficulties** • **Administration of the Kidd 50 ml water swallowing test** • **Assessment of pharyngeal sensation** • **Assessment of tongue protrusion** • **Referral to a trained dysphagia expert if the stroke survivor fails testing.**					
4. Demonstrates the ability to identify appropriate position protocols to support the stroke survivor for eating and safe swallowing to prevent aspiration.					
5. Demonstrates the ability to position the stroke survivor properly for eating, and uses the feeding and swallowing strategies identified by the team to prevent aspiration.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
6. Demonstrates knowledge about how positioning, feeding, pocketing and oral hygiene affect the potential for aspiration.					
7. Demonstrates the ability to assess, implement and evaluate strategies to promote oral care and dental hygiene.					
8. Demonstrates the ability to educate and support the stroke survivor and caregiver about dysphagia management.					
9. Collaborates with speech-language pathology and/or designated team members, to implement and evaluate a comprehensive plan of care.					
10. Demonstrates the ability to promote the stroke survivor to self-feed to reduce the potential for aspiration.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Skin Care					
1. Demonstrates the ability to identify the risk factors for skin breakdown using a standardized risk assessment tool (e.g., Braden Scale) and other aspects such as: • **Immobility and altered sensation** • **Nutritional imbalance** • **Incontinence/moisture** • **Aging/poor skin turgor** • **Friction and shearing** • **Co-morbidities that put the stroke survivor at risk (peripheral vascular disease, diabetes, previous skin breakdown, etc.)** • **Cognitive impairments** • **Adaptive devices.**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
2. Demonstrates and applies knowledge of the strategies for preventing skin breakdown including: • **Pressure reduction and relief** • **Pressure reduction and relief devices (e.g., beds, chair, extremity devices and appropriate footwear)** • **Routine position changes** • **General measures (e.g., preventative skin care, routine skin assessments, reassessment of therapeutic interventions, consultations with appropriate resources such as wound care clinician)** • **Friction/shear reduction** • **Bed position** • **Assistive devices and techniques** • **Protection of high-risk areas** • **Excess moisture reduction (e.g., incontinence management, avoiding foley insertion as appropriate, appropriate barrier protection)** • **Nutrition and hydration (e.g., food and fluid intake, regular monitoring of weight and biomedical indicators, consultation with appropriate resources).**					
3. Demonstrates and applies knowledge of the staging of wounds and their management: • **Pathophysiology of skin ulcers** • **Physiology of normal skin healing** • **Five staging of wounds** • **Management of each stage.**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
4. Provides education to the stroke survivor and caregiver regarding the skin treatment plan.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Continence Management					
1. Demonstrates knowledge of anatomy and physiology of normal bladder function, implications of age, co-morbidities, past urinary function history and other factors that may affect normal bladder function.					
2. Demonstrates knowledge of the effect of stroke may have on bladder function as determined by stroke location.					
3. Demonstrates the ability to assess and outline the stroke survivor's bladder functioning based on a health history, physical examination, monitoring and evaluation of bladder functioning.					
4. Demonstrates the ability to implement strategies that promote continence, independence, safety and prevent complications, such as: • **Early removal of foley catheter** • **Upright positioning with privacy** • **Ensure adequate bowel functioning** • **Ensure adequate fluid intake – 2 liters/day** • **Limit caffeine intake – especially later in the day** • **Limit fluid intake prior to bedtime** • **Provide access to assistive devices, i.e., bedpan, urinal and commode.**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
5. **Demonstrates the ability to recognize bladder impairment based on assessment:** • **Urinary retention with overflow incontinence/voiding.** • **Urgency incontinence.** • **Functional Incontinence**					
6. **Demonstrates the ability to implement and coordinate a bladder treatment plan based on the type of urinary voiding pattern:** • **Urinary retention with overflow incontinence/voiding, i.e., intermittent catheterization** • **Urgency incontinence, i.e., prompted voiding** • **Functional Incontinence, i.e., improving environmental access.**					
7. **Demonstrates the ability to evaluate the effectiveness of the treatment plan on improving bladder functioning**					
8. **Demonstrates the knowledge of pharmacological agents used to assist impaired bladder functioning, monitors for side effects, promotes stroke survivor education, and monitors for effectiveness of drug treatment.**					
9. **Demonstrates the ability to assess for common complications that affect continence, such as UTI, and develop, monitor and evaluate the plan of care as appropriate.**					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
10. Demonstrates the ability to collaborate with the health care team and specialists, as appropriate, to manage the factors that can lead to incontinence.					
11. Demonstrates the ability to develop and implement a stroke survivor education program for bladder self-management.					
12. Demonstrates the ability to support and educate the stroke survivor and caregiver related to their impairment in urinary function and its management					
13. Demonstrates knowledge of the anatomy and physiology of normal bowel function, implications of age, co-morbidities, past bowel function history and other factors that may affect normal bowel function.					
14. Demonstrates knowledge of the effect of stroke on normal function including constipation, fecal impaction, diarrhea, and/or neurogenic bowel.					
15. Demonstrates the ability to assess and outline the stroke survivor's bowel functioning based on a health history, physical examination, monitoring and evaluation of bowel functioning					
16. Demonstrates the ability to develop and implements a plan for the management the bowel incontinence / impaction.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
17. Demonstrates the ability to promote strategies that promote improved bowel functioning • **Routine toileting** • **Dietary interventions** • **Fluid intake - adequate fluid intake 2 litres/day** • **Proper positioning to promote evacuation (i.e., upright and with privacy).**					
18. Demonstrates the knowledge of pharmacological agents used to promote improved bowel functioning, monitors for side effects, promotes stroke survivor education, and monitors for effectiveness of drug treatment.					
19. Communicates observations to other team members and collaborates to promote early intervention when required.					
20. Demonstrates the ability to develop and implement a stroke survivor education program for bowel self-management.					
21. Demonstrate the ability to support and educate the stroke survivor and caregiver related to their impairment in bowel function and its management.					
22. Demonstrates the ability to educate stroke survivor on how to use wear protection, urinal, bedpan or commode independently to help control incontinence					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
23. Uses strategies to enable stroke survivors to communicate bladder/bowel needs if problem due to language or cognitive deficits (i.e., symbol boards or spaced retrieval techniques).					
24. Demonstrates awareness of the effect of bowel and bladder dysfunction on stroke survivor's/caregivers perception of deficit and impact discharge planning.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Primary and Secondary Stroke Prevention					
1. Demonstrates the ability to identify stroke-related risk factors and their management including: • **Non-modifiable conditions such as age, sex, race/ethnicity, genetic factors** • **Modifiable conditions such as behavioural (physical inactivity, smoking)** • **Predisposing conditions such as stroke, TIA, obesity, acute myocardial infarction, hypertension, hyperlipidemia, atrial fibrillation, diabetes mellitus, atherosclerosis (coronary heart disease, asymptomatic carotid stenosis, peripheral vascular disease), other cardiac disease, coagulation disorders, estrogen/ progestin, replacement therapy** • **Probable risk factors such as migraine, oral contraceptive use, alcohol abuse, stress, sleep apnea, sympathomimetic agents, illicit drug use, congenital cardiac anomalies.**					
2. Demonstrates knowledge of secondary stroke prevention management including: • **Pharmacology (antiplatelet and anticoagulant therapy, angiotensin-converting enzyme inhibitors, lipid therapy)** • **Surgery** • **Lifestyle and behaviour modifications.**					
3. Demonstrates the ability to educate the stroke survivor and caregiver about the rationale supporting secondary prevention management.					

LEARNING AREA	Date	*SELF-RATING Base	Mid	Final	Comments
Transition Management					
1. Demonstrates the ability to assess the stroke survivor and caregiver, in conjunction with the team, to determine the most appropriate discharge destination to meet the medical and nursing needs of the stroke survivor.					
2. Demonstrates the ability to identify environmental discharge barriers, and in collaboration with the team, support recommendations related to modifications and equipment needs.					
3. Demonstrates the ability to refer the stroke survivor to the most appropriate resources to meet ongoing medical and nursing needs.					
4. Demonstrates the ability to assess the caregiver's ability to manage the stroke survivor's care needs.					
5. Demonstrates the ability to work effectively with stroke survivors and caregivers to assist and support them with making decisions about the discharge process.					
6. Demonstrates an awareness of agency policies in relation to the discharge planning process.					
7. Demonstrates the ability to work in partnership with representative's from the next transfer point in the continuum to facilitate transfer.					

Appendix G

Draft Implementation Timeline for Phase 3

DRAFT IMPLEMENTATION TIMELINE FOR PHASE 3

WWCCAC	CP	SEHC	SERC		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9+
				Phase 2a									
				Process									
☑				A2 - Consider reimbursement for OT Lead work									
☑				E1-E3-E4 - Confirm pathway flexibility									
☑	☑	☑		F2 - Encourage creativity in communication									
				Evaluation									
			☑	A3 - Evaluate team work with AITCS									→ → → →
			☑	E5 - Evaluate care patterns and outcomes									→ → → →
				Phase 2b									
				Process									
☑				A1 - Confirm team/provider requirements									
☑				E2-F1 - Add 2-3 nursing visits to pathway									
			☑	F3 - Trial of Tyze									→ → → →
☑				G1 - Rename Discharge "Transition" x 2									
☑				G2 - Encourage attendance at Transition meetings									
	☑	☑		B1 - Revamp learning package for stroke									
			☑	B2 - Adapt self evaluation templates									
				B3 - Use self assessment tools							→ → → →		
			☑	B4 - Hold workshop on roles									
			☑	B5 - Report on roles									
			☑	B6 - Produce role training packages									
				Evaluation									
			☑	A4 - Develop measure of incremental benefit									
			☑	G4 - Monitor transitions and use WatLX									→ → → →
			☑	B7 - Evaluate training packages									→ → → →
			☑	B8 - Evaluate self assessment tools									→ → → →
				Phase 2c									
				Process									
			☑	C1 - Develop goal-setting approach									
	☑	☑		C2 - Adopt the goal-setting approach									
			☑	C3 - Design Client Record									
☑				F1 - Align hospital-home care communication									
	☑	☑		G3 - Make referrals to community services				→ → → →					
				Evaluation									
			☑	C4 - Evaluate goal-setting approach									→ → → →
			☑	C5 - Evaluate client-provider goal alignment									→ → → →
				Phase 3									
			☑	H1 - Research outpatient/home-based therapy									→ → → →
☑				H2 - Identify options for outpatient therapy									→ → → →

☑ lead