ONTARIO STROKE NETWORK STROKE DISTINCTION REPORT

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Focus of accreditation (check all that apply)
- Acute Stroke Services
- Inpatient Rehabilitation Services Standards
- Standards for Providing an Integrated System of Services to People with Stroke

Date accreditation process started (dd/mm/yy): 15/09/2012 (Application to Accreditation Canada)
Date accreditation process completed (dd/mm/yy): 17/09/2013 (On-Site Survey)
  25/9/1013 (Distinction Award Letter)
Date of report (dd/mm/yy): 17/01/2014 (OSN Report Submitted)

1. Why did your organization decide to embark on the Stroke Distinction process?

Bridgepoint Active Healthcare has been on an exciting and innovative journey to become Canada’s leader in rehabilitative care. Stroke Best Practices in addition to other evidence informed practices are foundational as we continue to improve and evolve our inpatient and outpatient stroke programs and services.

Bridgepoint has been offering stroke rehabilitation services many years including high intensity short duration (HTSD), high-intensity long duration (HTLD) and low-tolerance long duration (LTLD) for patients with all levels of stroke severity. Bridgepoint has taken an active role with system partners to continually evaluate and improve the stroke care delivery model internal to our organization and across the system.
In 2011, the Toronto Central Local Health Integration Network (TCLHIN) in partnership with the GTA Rehab Network reviewed stroke services across the region which resulted in the development of organization-specific recommendations. The recommendations were intended to ensure consistent stroke care across service providers and system-level improvements in alignment with the Canadian Stroke Best Practices. At the same time, Bridgepoint was in the process of completing a comprehensive review of all inpatient and outpatient services in preparation for the transition to a brand new state of the art purpose-built rehabilitation and complex continuing care hospital. Based on feedback from internal and external stakeholders and the TCLHIN recommendations, Bridgepoint made a strategic decision to become an early adopter of the stroke best practices and committed to the reallocation of existing resources to meet the requirements for best practice service delivery. Bridgepoint considered actions that could be taken immediately in the existing facility, established directions for care in the new facility and created a phased approach to the future alignment of stroke services.

As Bridgepoint began to embark on Phase One of the stroke services realignment, we became aware of the Ontario Stroke Network grant designed to support organizations interested in pursuing Stroke Distinction through Accreditation Canada. Stroke Distinction was seen as an opportunity to acknowledge Bridgepoint’s commitment to stroke best practices and would serve as a mechanism to formally recognize the work of the dedicated staff in the inpatient and outpatient stroke services. With further investigation, it was noted that the Stroke Distinction program offered a systematic approach to evaluate stroke services and identify opportunities for improvement. The Stroke Distinction indicators, protocols and standards created infrastructure to support prioritization of initiatives and focused the work of the stroke distinction steering committee and working groups.

Phase one of stroke services realignment at Bridgepoint occurred in June 2012 with an increased allocation of therapy staff to inpatient and outpatient stroke rehabilitation and a focus on directing referrals to the most appropriate services. With greater emphasis on directing referrals for mild strokes from acute care directly to outpatient services, more moderate and severe strokes gained access to high intensity rehabilitation. In April 2013, the second phase of the stroke service redesign occurred with the integration of 20 high intensity (Rehab) and 28 reconditioning (CCC) rehabilitation beds within the same program on the third floor of the new facility. Bridgepoint now admits the highest percentage of moderate and severe strokes across the TCLHIN and has become an exemplar in FIM efficiencies when benchmarked across peer organizations.

2. What was the outcome of the accreditation process?

Bridgepoint Active Healthcare was awarded Stroke Distinction status on September 25, 2013. See Appendix A for the final report of the results.

3. What organizational changes occurred as a result of your participation in stroke distinction (e.g., processes, policies/procedures, buy-in, attitude, positive or negative unintended consequences) and what was the reaction from those involved with the Stroke Distinction process (e.g., Senior Administration, Staff and Physician Leads)?

Governance Structures
At the outset of our stroke services realignment, Bridgepoint established a formal planning and implementation structure led by a steering committee with representatives from senior leadership and management and three working groups with representation from front-line clinicians, management and cross-functional departments (human resources, finance, IT, food & environmental services) to address the complexity of the implementation.

As the focus of the work transitioned from realignment of resources and services to implementation of best practices a revised three-tiered committee structure was created. The structure consisted of a Steering Committee, a planning and development committee and implementation working groups to address the core elements of Stroke Distinction.

To improve integration and ensure sustainability of stroke best practices, an Excellence in Stroke Care Committee has been created and formally integrated into the hospitals existing governance structure. The Excellence in Stroke Care committee has reporting accountability to Program Councils and is responsible for development, oversight and implementation of a stroke best practices work plan. The committee has representation from inpatient and outpatient front-line staff and management as well as senior leadership.

Program Evaluation

Though Bridgepoint has been closely monitoring stroke service indicators over the last 5 years, the Stroke Distinction process provided additional infrastructure and measures that increased our ability to evaluate the quality of services provided against a comprehensive set of standards. One of the first activities completed by Bridgepoint in our pursuit of Stroke Distinction was the completion of a gap analysis to determine our current performance against the best practices and identify any opportunities for improvement. To ensure all indicators, protocols and standards were captured and consistently documented during the review a Stroke Distinction gap analysis tracking tool was created prior to initiating the review. The gap analysis was completed through a review of available metrics, from interviews with content experts (members of the stroke care team), review of the tools and resources available for stroke care across the organization, observation of unit practices and processes and health record audits.

Corporate Priorities

Over the past two years elements of Stroke program redesign have been identified as key change initiatives to support successful achievement of outcome indicators for our corporate Quality Improvement Plan.

The evaluation of our stroke programs through the Stroke Distinction process has allowed us to refine our change initiatives through the identification of high impact areas for emphasis. The improved reporting of specific metrics has increased the awareness of staff at all levels of the organization regarding ongoing performance.

Stroke Distinction designation, in addition to our exemplary quality and operational outcomes, has positioned Bridgepoint as leader in stroke care within the TCLHIN. At a time when there is increased emphasis on the core domains of quality (effectiveness, access, efficiency, patient centredness and integration) and a need for fiscal responsibility within the healthcare sector, Bridgepoint has an opportunity to leverage our Stroke Distinction status to influence conversations regarding resource allocation across the system.

Acknowledgement, Recognition and Interprofessional Team Dynamics
Confirmation of Bridgepoint’s participation in the stroke distinction process came at a challenging time for the stroke teams given the massive organizational transformation. Over the past two years changes included the realignment of stroke services and the relocation to a new facility that resulted in the reconfiguration of the interprofessional teams and redesign of workflow. With reassurance that the team was already employing many best practices and that Distinction was an opportunity to validate the work already underway, the teams were engaged and highly motivated to achieve a successful outcome.

Teams demonstrated commitment to the process and worked together to identify excellence in care processes within and across disciplines and opportunities to create new and better ways to work. The stroke distinction process helped interprofessional team members learn more about the activities of their colleagues and gain a greater appreciation for the contributions of every team member. Increased awareness of roles also enabled improved referral processes and carry over of treatment plans across disciplines.

The formal Stroke Distinction award resulted in a tremendous and well-deserved sense of pride among the stroke teams and the organization as a whole. There was a differentiation noted between Stroke Distinction and the more generalized hospital Accreditation. Being awarded Stroke Distinction provided “special” status for providing best practice care that exceeds minimum standards and requirements of practice.

**Awareness of Stroke Best Practices**

Bridgepoint has been an actively engaged participant in local and regional stroke forums and has been regularly monitoring stroke-related indicators for years, however, stroke knowledge tended to be localized with key content experts. Participation in the Stroke Distinction process created a vehicle to encourage broader dissemination of information and contributed to an increased awareness of stroke best practices across the organization. Staff were extremely appreciative of opportunities to learn more about best practice through venues such as ‘lunch and learns’ and were receptive to introduction of new and existing resources.

**Policies, Procedures & Protocols**

Stroke Distinction also stimulated a review of existing policies and procedures and allowed for identification of areas requiring more formal documentation to support best practice. There were several policies, procedures and protocols revised or generated to meet Distinction standards:

- There was a comprehensive review of the Diabetes best practices, creation of diabetes management guidelines and resources and education sessions offered to our inpatient and outpatient stroke teams to support implementation.

- The SLP dysphagia screening protocol was formally documented and the team began to review standardized assessment tools that may be appropriate for our patient population.

- A complete VTE protocol was created and implemented including guidelines, assessments, order sets and patient education materials.

- Through the gap analysis it was determined that although all patients were being screened for depression on admission, a standardized tool was not being consistently
used. Social work piloted and began to implement a standardized depression screen for all patients and will evaluate impact in care delivery.

- A consistent approach to document patient and family education was agreed upon by all team members to ensure improved access to information to support care planning.

**Stroke Research**

The Bridgepoint Collaboratory for Research and Innovation leveraged the focus on stroke best practices to begin an investigation into the evidence regarding the application of stroke best practices for our complex patient population. The Collaboratory is interested to learn more about the efficacy of best practices in the context of multi-morbidity and variability in the determinants of health in complex patient populations.

The Collaboratory is also embarking on innovative work to better understand complexity and in particular how members of the Stroke team define patient complexity. The clinical experience of complexity is providing system-level, provider-level and patient-level insights into the elements that contribute to complexity.

4. **What do you feel are the key lessons learned?**

   a) Executive endorsement of the project as a priority is essential to ensure appropriate allocation of time and resources to support the initiative. Inclusion of stroke indicators in corporate reporting documents such as the corporate operating plan and the Quality Improvement Plan (QIP) create formal leadership accountabilities and facilitate an ongoing focus on the work required.

   b) Establishing formal project management structures and processes ensures there are clear accountabilities, timelines and deliverables. We would recommend development of a project charter as a first step in the Stroke Distinction process. The charter provides an opportunity to document, share and monitor core elements of the project including the Stroke Distinction requirements, the project committee structure, key stakeholders, scheduled timelines and priority deliverables. The project charter functioned as tool to support consistent communication among committee structures, helped to keep the momentum going throughout the duration of the project and clarified expectations for committees and individuals.

   c) Development of centralized information repositories, written processes and reporting documents that can be accessed referenced and used by all team members is essential. At Bridgepoint we created a shared folder on a network drive and a SharePoint site accessible to all team members. We also ensured documents and presentations were available to teams through email pushes for those clinicians who were less directly involved in project work.

   d) Create a Stroke Distinction self-assessment tool. The tool provided a foundation for a gap analysis to identify areas for improvement related to the required indicators, protocols and standards. To document current state and track progress, we used a stop light system of green, yellow and red to reflect our performance against the requirements. Completion of the self-assessment allowed us to identify priorities and generate a work plan roadmap for the project.
e) Engage front-line staff including physicians early in the decision to apply for Stroke Distinction and in the Stroke Distinction preparation process. The application for the OSN Grant and the Stroke Distinction process was primarily managed by leadership. This created some challenges with initial roll out of the program as some staff interpreted the Stroke Distinction process as a top-down decision with significant resource implications. Staff concerns were mitigated by the high level of involvement by leadership in the direct support of the project and constant recognition of staff contributions to the process.

f) Do not underestimate the amount of work required for a successful Stroke Distinction survey. Although at first glance there was a sense that the teams were already meeting many of the requirements for stroke distinction, there was still significant time and effort required to pull everything together to address gaps and demonstrate evidence of performance.

g) Celebrate successes during the planning phase. It became apparent early on how hard the teams were already working and regardless of stroke distinction results, the hospital took the time to recognize and thank the teams for the quality of care they provide everyday.

h) Support clinicians to access best practice resources and structure opportunities for staff to reflect on current practices. Formally booking meetings and working sessions with clinical teams supported clinicians to step out of the business of a patient care day and allowed project work to proceed on a timeline.

i) Conducing table top and mock episodes of care tracers were extremely effective and well received by the clinical team members. They appreciated having the opportunity to answer questions and being observed as a way to prepare for the onsite survey visit.

j) Collaboration between clinical team members, support departments, leadership and external partners was absolutely required to ensure all areas with opportunities to influence best practices were aware and involved in the process.

5. How is your organization planning to sustain the Stroke Distinction momentum?

a) We will continue to actively participate in local, regional, and provincial stroke forums and refer to available best practices resources to direct our future work.

b) We have formalized an Excellence in Stroke Care Council, which has reporting accountability to the Rehab Program Council. The Council has membership from inpatient and outpatient clinicians and managers as well as representation from program and corporate leadership. The council is in the process of establishing clear objectives and deliverables according to a 2-year strategic work plan.

c) Regular review of our Stroke indicators with formal dissemination of results to the stroke team clinicians to celebrate successes and support continuous quality improvement.

d) Inclusion of Stroke indicators into corporate planning and reporting (Annual Operating Plans, Quality Improvement Plan).
e) We have connected with other organizations who have obtained stroke distinction and we have identified opportunities for collaboration and information sharing. We will share our experiences with other organizations interested in pursuing Stroke Distinction.

f) Depression screening, swallowing and VTE protocols have been built into practice and regular audits will occur.

g) We will continue to draw upon and refine existing indicator reports and this information will be reviewed regularly at the Excellence in Stroke Care Council, and fed back to the clinical teams.

h) Annual Stroke report will be refreshed to include stroke distinction updates, including compliance with standards and best practices, innovations in care and research activity that contributes to new learning in the area of stroke.

i) Leadership will have specific stroke distinction accountabilities and deliverables in their annual Leadership Plans.

j) Our work with the Research Collaboratory will continue and will help inform future development as we strive to better understand how the best practices apply to patients with complex health issues.

k) We are exploring opportunities to expand our stroke expertise to other geographic regions through virtual mediums (i.e., Tele-Stroke).

6. **What aspects of the Stroke Distinction process should be improved? (Please list in order of priority and provide recommendations on individuals and/or collaborations that could lead/support these changes)?**

a) Standardized Self-Assessment Process – Having a standardized, structured tool available to assist organizations to evaluate current practices against stroke distinction requirements would eliminate the need for every site to establish their own tools to manage this process. A Stroke Distinction self-assessment tool would be consistent with the Accreditation Canada process employed for hospital-wide accreditation and could automate time-consuming elements of the interview process we employed during our current state analysis. An electronic self-assessment would also facilitate border stakeholder feedback and evaluation over time.

b) Metrics and data collection – the Stroke Distinction Accreditation program is a national program and as a result has incorporated metrics that may not be relevant to all organizations based on discrepancies in regional and provincial management of stroke care.) Population health indicators and standards are collected and monitored differently based on the type or organization and their relationship with the health system.

c) Stroke Distinction Accreditation Cycle - The 2 year cycle for the Stroke Distinction process is relatively short compared to the hospital-wide Accreditation Canada process. The two year cycle can be somewhat challenging when process improvement initiatives and strategies for continuous quality improvement may require more time for implementation, evaluation and sustainability. The frequency of Stroke Distinction survey may also be somewhat cost prohibitive and resource intensive for organizations with limited budgets in the context of health funding reform. Organizations must consider the
time and resources required to prepare for the on-site survey for a single patient population among many other populations served.

In contrast, the mandatory six month indicator reporting cycles keeps stroke best practices at the forefront and encourages ongoing quality improvement in response to performance.

Is there a way to determine if the mandatory data submission is sufficient to maintain standards over a longer survey period?

d) Access to resources (Accreditation site) – in our initial decision to apply for Stroke Distinction we completed a preliminary review of the program on the Accreditation Canada Website, however, it was not until we gained access to more comprehensive Stroke Distinction materials that we became aware of the expectations and requirements of the program. If there is a way to provide some additional detail to the information on the publically accessible website it might help organizations investigating to option of Stroke Distinction. An opportunity to preview expectations prior to submitting an application (scan before/no standards available)-better sense of commitment

e) Some standards may be more applicable or more developed at sites where there has been regional prioritization and system integration facilitating uptake of inter-organizational initiatives (i.e. Telestroke more advanced in other provinces, system level data collection)

7. What advice do you have for other centres considering preparing and applying for stroke distinction?

- Engage and obtain support and endorsement from senior executive, leadership and physicians
- Incorporate Stroke Distinction into the organizations strategic priorities
- Review Stroke Best Practice Recommendations and conduct a gap analysis prior to applying for Stroke Distinction. The gap analysis will assist in determining the amount of time and effort required for a successful Stroke Distinction survey.
- Plan well in advance by creating a project management structure and work plan to ensure implementation of required initiatives.
- Create a formal project management structure (formal project lead, steering committee and working groups) to support the advancement and pace of work.
- Clinical team engagement from day 1. Include clinical teams in all aspects of planning and work.
- Be creative and engage patients and families wherever possible in addition to feedback mechanisms already in place.
- Build on work already in progress wherever possible. This will reduce extra work and will support sustainability.
• Connect with other Stroke Distinction programs as well as stroke networks and communities of practice. There is much to learn from each other as stroke best practices continue to evolve.

8. Which resources at Accreditation Canada did you find most helpful?

• Accreditation Canada:

The following documents were constantly referenced by the stroke distinction committees, working groups and clinicians throughout the process. The organization, level of detail and definitions provided were extremely helpful to the end user.

a. Stroke Services Distinction Information Package—This documented provided an overview and summary and description of the five requirements for stroke distinction which include: standards of excellence, performance indicators, protocols, excellence in innovation and client and family education. This document was shared with the clinical teams as an introduction to the planning required for stroke distinction.

b. Distinction Standards for Inpatient Stroke Rehabilitation Services—This document provided a complete list of the required standards and served as the foundation of our self-assessment.

c. Stroke Services Excellence and Innovation. This document provided an explanation and clear criteria for the team to use to demonstrate that they are meeting the requirements for excellence in innovation.

d. Distinction Program Core Performance Indicators. This document provides a list of core and optional performance indicators that were used as a quick reference for educating teams on the requirements.

e. Stroke Services Client and Family Education. This document provided clarification on the evidence the surveyors would require during their site visit.

f. Accreditation Representative was extremely helpful in addressing questions and clarifying expectations for our site. were responsive to questions

We also want to acknowledge the value of participating in the Ontario Stroke Network teleconferences with other grant recipients. We were able share questions, strategies and solutions early in the process and have since made connections to discuss approaches to sustainability.

9. Have you developed any resources that you would be willing to share? If so please describe, attach and/or provide links:

a) Accreditation Canada Stroke Distinction Award Letter and Report

b) Bridgepoint Annual Stroke Report 2013

c) Stroke Distinction Self-Assessment Template

d) VTE Risk Assessment and Patient Education Pamphlet for VTE
e) Clinical Protocol Example – Swallowing Assessment & Algorithm
f) Clinical Team Lunch and Learn Power Point Presentation Sample (Stroke Services Distinction)
g) Stroke Education Series Plan and Sample Module

10. **Any other information you’d like to share?**

The Stroke Distinction process enabled recognition of the excellent care provided by Bridgepoint’s inpatient and outpatient stroke care teams. In addition it provided formal acknowledgement of our organizational commitment of the commitment to ensuring delivery of best practice care for people recovering from and living with stroke.

We are now exploring methods and opportunities to apply our stroke best practice implementation framework to other patient programs across the organization and challenging ourselves to evaluate best practices in light of patient complexity.

Bridgepoint Active Healthcare would like to take this opportunity to sincerely thank the Ontario Stroke Network for your generous funding support, guidance and facilitation of sharing among Stroke Distinction partner organizations.
September 25, 2013

Ms. Kate Wilkinson  
Director, Quality & Patient Safety  
Bridgepoint Active Healthcare  
14 St. Matthews Road  
Toronto, Ontario  
M4M 2B5

Dear Ms. Wilkinson:

Accreditation Canada is very pleased to recognize Bridgepoint Active Healthcare for earning **Distinction in Stroke Services** for the following site and program:

- Bridgepoint Hospital

Achieving Distinction indicates that your organization has demonstrated national leadership in the provision of high-quality stroke care. We applaud your success and urge you to celebrate this achievement.

As you know, Distinction requires an ongoing commitment to the highest levels of quality service. To maintain Distinction status, it is important to continue submitting performance indicator data through the Quality Performance Roadmap on your portal.

For additional information on submitting indicator data or on any other aspect of the program, please contact Geneviève Martin, Manager, Client Services at 1-800-814-7769 extension 371.

Congratulations to the leadership, clinicians, and staff at Bridgepoint Active Healthcare for your outstanding commitment to excellence and innovation in stroke services.

Sincerely,

Suzanne Larocque,  
Chair, Accreditation Decision Committee
Confidentiality Statement

The results of this stroke distinction survey are documented in the attached report, which was prepared by Accreditation Canada.

This report includes information obtained from the organization. Accreditation Canada relies on the accuracy of this information to conduct the survey and to prepare the report. Any alteration of this report would compromise the integrity of the accreditation process and is strictly prohibited.

While this confidential report is intended for the organization, Accreditation Canada encourages that the information herein be disclosed and promoted, in the interest of transparency, to stakeholders, clients and their community.
# Table of Contents

- About the Stroke Distinction Report pg. 2
- Stroke Distinction Decision pg. 3
- Results Summary pg. 3
- The Stroke Standards pg. 4
  - Inpatient Stroke Rehabilitation Services pg. 4
- Demonstrating Excellence and Innovation pg. 7
- Client and Family Education about Stroke pg. 15
- Stroke Services Protocols pg. 16
- Performance Measures pg. 17
- Next Steps pg. 19
About the Stroke Distinction Report

This report includes the official stroke distinction information based on the evaluation of the organization's stroke services.

The report can be used to communicate the success of stroke services to the public and staff.

Please visit the Organization portal (https://www3.accreditation-canada.ca/) for details of findings. The detail on the Organizational Portal will allow the organization, sites, and teams to review the stroke distinction results in detail and use the information for ongoing quality improvement initiatives and to monitor improvements.
Stroke Distinction Decision

Accreditation Canada is very pleased to recognize Bridgepoint Active Healthcare for earning **Distinction in Stroke Services**.

The national standards for Stroke Distinction were developed with input from key content experts and in collaboration with the Canadian Stroke Network. The Accreditation Canada Stroke standards are based on the best available evidence for stroke services, including the Canadian Stroke Strategy Best Practice Recommendations for Stroke Care (Update 2010).

In order to achieve Stroke Services Distinction, you must have at least 75% of criteria rated as “Met” and at least 90% of high-priority criteria rated as “Met”. The following table summarizes your achievement of these thresholds.

<table>
<thead>
<tr>
<th>Bridgepoint Active Healthcare</th>
<th>Achievement</th>
<th>Met</th>
<th>Unmet</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standards</td>
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<td>83</td>
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<tr>
<td>Indicators</td>
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<td>100.0%</td>
</tr>
<tr>
<td>Protocols</td>
<td>✔</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>100.0%</td>
</tr>
<tr>
<td>Excellence &amp; Innovation</td>
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<td>10</td>
<td>80.0%</td>
</tr>
<tr>
<td>Education</td>
<td>✔</td>
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<td>0</td>
<td>8</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Results Summary**

**Inpatient Stroke Rehabilitation Services**

The following section of the report summarizes your achievement of the inpatient stroke rehabilitation services standards, organized by standards subsection.

<table>
<thead>
<tr>
<th>Bridgepoint Active Healthcare</th>
<th>Criteria met</th>
<th>High priority criteria met</th>
<th>Unmet criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investing in comprehensive stroke rehabilitation services</td>
<td>4/4 100.0%</td>
<td>1/1 100.0%</td>
<td>0/4 0.0%</td>
</tr>
<tr>
<td>Engaging a prepared and proactive acute stroke rehabilitation team</td>
<td>16/17 94.1%</td>
<td>4/4 100.0%</td>
<td>1/17 5.9%</td>
</tr>
<tr>
<td>Providing safe and appropriate inpatient rehabilitation services</td>
<td>32/32 100.0%</td>
<td>5/5 100.0%</td>
<td>0/32 0.0%</td>
</tr>
<tr>
<td>Helping clients and families live with stroke</td>
<td>17/17 100.0%</td>
<td>1/1 100.0%</td>
<td>0/17 0.0%</td>
</tr>
<tr>
<td>Maintaining accessible and efficient clinical information systems</td>
<td>7/7 100.0%</td>
<td>0/0</td>
<td>0/7 0.0%</td>
</tr>
<tr>
<td>Monitoring quality and achieving positive outcomes</td>
<td>6/6 100.0%</td>
<td>2/2 100.0%</td>
<td>0/6 0.0%</td>
</tr>
</tbody>
</table>
The Stroke Standards

Inpatient Stroke Rehabilitation Services

This part of the report provides information on the delivery of high quality and safe inpatient stroke rehabilitation services. Specific priority process areas that are evaluated include: clinical leadership, competency, episode of care, and impact on outcomes.

Improvements

Following the on-site visit is the opportunity to address the unresolved criteria. Below are criteria that were rated not met:

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Evaluator Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.6 The team uses telehealth to increase access to provide stroke specialists.</td>
<td>Telehealth has been used by the organization to assess readiness for rehabilitation admission, but is not routinely utilized for assessment or follow-up of patients discharged from the organization.</td>
</tr>
</tbody>
</table>

Clinical Leadership

The clinical leadership team exhibits a commitment and drive to become a leader in complex rehabilitation care (emphasis on stroke rehabilitation). The team has a solid understanding of the populations it serves, the need for information to support decision-making, and awareness that integration of best practices for stroke care with standard care processes takes time and a continuous quality improvement focus. The organization collaborates with community agencies and partners in understanding the ethnocultural diversity of their target population(s), and the need for engagement strategies to target high-risk and hard-to-reach populations. There is an ongoing focus on identifying barriers to good transitions into the organization, across programs within the facility, and in exit strategies for return to community. The team takes a risk management approach to identifying and minimizing barriers.
Competency

The expert and interprofessional approach to inpatient stroke rehabilitation service delivery is highly evident. This is a truly interprofessional and cross-boundary approach to care and service to the stroke population. The ability to ‘transition-in-place’ within the walls of one organization is a strength, minimizing stress and enhancing the continuity of care provided. While there are clearly defined roles and responsibilities in stroke service delivery, all team members appear to function as a unit in ensuring that the patient and family/caregiver needs are met. There is evidence of cross-discipline communication and acknowledgment of the professional skills and expertise of the various team members in leading aspects of patient care. For example, the physiotherapist or occupational therapist may be the primary support person for one client, the nurse or speech language pathologist for another, depending on the individual client needs. New staff and service provider orientation is apparent at intake and is ongoing in terms of support and access for professional development and training. Information is obtained from staff evaluations/surveys to improve stroke rehab services. In-services, education sessions, and training opportunities are evident in ensuring evidence-based practices (Canadian Best Practice Recommendations for Stroke Care) are utilized in the assessment and management of stroke clients, families/caregivers.

Episode of Care: Inpatient Stroke Rehabilitation Services

Formal intake criteria are available; given the natural fluctuation in stroke occurrence and low census at times, criteria are flexible in terms of admissions. Standardized assessment tools are used during intake and throughout the inpatient stay to assess function and recovery, and to guide the rehabilitation team in its care. Referral processes and intake criteria are clearly articulated for inpatient stroke rehabilitation to all referring centres; flexibility is key in the assessment process. A strength of Bridgepoint Active Healthcare is the focus on those patients with moderate to severe stroke. These patients typically spend longer in acute care before being transferred for active rehabilitation, but this is not the case at Bridgepoint Active Healthcare; rehabilitation referral requests are responded to very quickly, often less than 15 minutes from receipt! The staff members receiving referrals are very skilled at assessing referral information and will contact the referring centre for additional information as required, to enable rapid decision-making at the receiving end. Time frames are tracked and reported regularly to ensure the team is meeting established targets for referrals.

There is a full complement of trained and skilled rehabilitation and professional staff (inpatient and outpatient) who assess and manage all aspects of patient care needs, such as physical therapists, speech language pathologists, occupational therapists, cognitive and mental health professionals. Communication between inpatient and outpatient departments is ongoing. At least 50% of Bridgepoint Active Healthcare inpatient stroke patients will go on to receive outpatient therapy. The stroke team is truly integrated; the physiatry and medical staff are very much a part of the team of care providers and are not seen as the automatic team leaders. The commitment to providing accessible stroke rehabilitation to patients with moderate to severe stroke may be challenged in the near future as the government funding model changes for inpatient/outpatient health programs. Much of important staff ‘work’, particularly in the outpatient environment, occurs outside of direct client interaction; this is generally not considered in funding models yet is an integral part of providing best care to clients. An additional area of potential concern, from a management/leadership perspective, relates to the potential 7-day/week admission and service model. This will lead to challenges in the staffing model, rapid response times for assessments and screening processes, etc.
Decision Support

The Bridgepoint Active Healthcare inpatient stroke unit has a highly integrated electronic medical records (EMR) system. All team members (except physicians) currently document on the computer, with portable units available in most areas, thus documentation occurs quite quickly following the assessment(s). Data updates are current and timely. The outpatient department is also integrated with the EMR, so reports and data from the inpatient stay are readily accessible to the staff providing ongoing care in the ambulatory clinics. The leadership team recognizes that openness is valued by all staff and shares reports generated about stroke system performance to move the team and organization towards quality improvement. The stroke rehabilitation program is based on best practices for stroke care and staff members (clinical leaders, decision support) utilize the best practices for stroke care and stroke rehabilitation to guide program development. It is suggested that the reference links to Evidence Based Guidelines on the electronic health record be enhanced for easy access. FIM data are entered in a timely manner and decisions based on these scores are made earlier than before, due to the availability of this data. Financial information is beginning to mix with outcome measures; the inclusion of these data adds another level of integration with decision-making capacity. CIHI data are obtained quarterly and consideration should be given as to how to improve access to this data in a usable, timely way. It is also suggested that outcome data be validated with respect to reductions in length of stay, i.e., given the increase in stroke severity in the inpatient population, does this relate to changes in outcomes?

The following are suggested areas for improvement:
1) Implementation of medication management electronically. The current requirement to enter information into e-medication system manually introduces potential for error;
2) Physician order entry needs to be implemented to reduce need to enter verbal/written orders manually into the system (active physician and program committee meetings related to integration of IT processes with active care delivery processes are occurring) and
3) Duplication of data from admission process needs addressing.

Impact on Outcomes

This is another strength of the Bridgepoint Active Healthcare inpatient stroke rehabilitation program. Clinical and service utilization data drive program improvement across the system. Process and outcome performance measures are used to help with program planning, development initiatives, and help to focus research studies. Research initiatives target issues that will identify key drivers and indicators for patient care and staff development, thus improving the quality of inpatient stroke services and supporting the organization in its goal to become a national leader in complex rehabilitation care. Patients and family are very much a part of the information pathway; feedback is solicited during the inpatient stay and upon discharge. The leadership team takes this feedback seriously in planning processes around quality improvement. For example, there is a patient/family engagement strategy being developed (Nov 2013) that relates to investing in patients and families differently. Programs are developed based on feedback, such as the Mindful Connections (peer support program for young patients aged 18-55) program for neuroscience patients; a patient stroke education series that recently drew over 34 attendees to one session; and the IPoB program (an interprofessional buddy program) for mentoring, practice and collaboration program for new employees. We would encourage additional staff education to focus on some of the less ‘talked about’ issues related to stroke recovery and rehabilitation - for example sexuality and incontinence - to reduce staff discomfort in discussing these issues with patients. As well, advanced care planning is a topic of increasing focus in the best practice standards and staff members should be encouraged to engage with clients and families in ongoing conversations around this issue (e.g. use of My Voice workbook). While the social worker does initiate conversations related to this, as well as advanced directives, all staff should be ready to initiate and engage in conversations.
Demonstrating Excellence and Innovation

Excellence and innovation are key components of effective stroke services. Accreditation Canada supports excellence and innovation by requiring stroke services to implement projects or initiatives that utilize the latest knowledge, integrate evidence, and align with best practice guidelines.

Below are the results from organization implementation of excellence and innovation in stroke services.

Implementation of the Ottawa Model for Smoking Cessation (OMSC)

Background

As a leader in the prevention and management of complex chronic disease, Bridgepoint Active Healthcare manages, delivers, researches and teaches leading healthcare practices so that people with complex health conditions can live better. Bridgepoint is committed to ensuring a safe, healthy and clean environment for patients, employees, volunteers, visitors and the general public. Bridgepoint made a decision to implement a smoking cessation program and expand its smoking policy based on evidence that demonstrates:

- smoking is the leading cause of preventable disease and death in Ontario;
- smoking is a major risk factor for the development of health conditions such as stroke & heart disease;
- exposure to second-hand smoke is a serious health hazard that can lead to premature death in children and non-smoking adults; and
- there is no safe level of exposure to second-hand smoke.

Smoking takes a high toll on the health of Canadians and significantly increases financial burden to the healthcare system. Implementing an evidence-based smoking cessation program at Bridgepoint is a powerful preventative intervention to produce health benefits for our patients living with complex conditions who smoke, and their loved ones. According to the Canadian Best Practice Guidelines for Stroke, “All members of the interdisciplinary team should address smoking cessation and a smoke-free environment at every healthcare encounter for active smokers”. When asked, four out of five Bridgepoint patients who smoke think it is important for them to quit, and over 62% of smokers want to quit during their current hospital stay (over 75% on our Stroke & Neurological Care units).

A smoking cessation program needs to recognise that tobacco addiction is a chronic and relapsing condition that is treatable. Using the hospital setting is an efficient and effective way to identify and offer non-judgmental, systematic support and treatment to people who smoke, and increases the quit attempts of smokers who want to quit. Furthermore, providing smoking cessation aligns with the emerging consensus that health care professionals have a duty of care when tobacco addiction is identified, and with the Registered Nursing Association of Ontario’s (RNAO) Best Practice Guideline to incorporate smoking cessation into daily nursing practice.
Bridgepoint’s Smoking Cessation Program

Smoke-Free Bridgepoint is a three-pronged approach that makes Bridgepoint a smoke-free environment both inside and out. The approach focuses on:

1. **Policy** - To revise, implement and enforce a new Smoke-Free Policy;
2. **Practice** - To adapt and implement the best practice Ottawa Model for Smoking Cessation (OMSC) in a complex rehabilitation and complex care setting; and
3. **Environment** - To transform Bridgepoint to a smoke-free environment and culture.

Review of the literature, smoking cessation interventions and experiences from other hospitals’ highlighted common issues and challenges, as well as evidence-based program designs. The core concept of our systematic approach is based on the best practice OMSC and the ‘4A’s’ of the RNAO and includes:

1. Patient Tobacco Use Identification
2. Documentation and Referral
3. Strategic Advice
4. Pharmacotherapy
5. Follow up and Support

A systematic approach to patient identification and offering of smoking cessation during a hospital stay results in an increase in quit attempts and rates of quitting amongst smokers. A study that examined the reach, efficacy, adoption and implementation of the OMSC in 9 Ontario hospitals led to an absolute increase of 11% for continuous smoking abstinence rates measured at 6 months.

**Phase 1 - OMSC Implementation** (Sept 2011- ongoing)

After receiving an initial OMSC grant (awarded to 5 hospitals in Ontario, funded by the Heart & Stroke Foundation) to work with the University of Ottawa Heart Institute (UOHI) to implement the Ottawa Model, Bridgepoint planned, adapted and implemented the best practices OMSC across all inpatient units prior to opening our new hospital in April 2013. Bridgepoint is the first and only freestanding complex care and complex rehabilitation facility in Ontario to implement the Ottawa Model.

**Project Milestones:**

1. Executive/Senior Team endorsement - Sept/11
2. Identification of clinical champions and coordinator - early Sept/11
3. Development of OMSC Implementation plan (with UOHI support) - Oct/11 to May/12
4. Piloted OMSC implementation and made adaptations for a rehab & complex care setting using Continuous Quality Improvement (CQI) cycle - Summer/12
5. Organization-wide education and rollout to all inpatient units - Sept to Apr 2013
6. Bridgepoint’s adapted OMSC model for complex rehab & complex care presented at various knowledge exchange/network forums & national conference (see below)
7. Ongoing program evaluation and CQI for process improvements, including a process to assess safety of ‘high risk’ complex patients not interested in quitting
8. Expansion of OMSC to Ambulatory Care, including free Nicotine Replacement Therapy (NRT) for discharged patients - upcoming Fall-Winter 2013

**Results to Date:**

- Established baseline smoking rate of 21% (over 1 in 5 of our patients)
- Pre-implementation Staff Surveys - included opinions and views regarding hospital-based smoking cessation services prior to program implementation
- OMSC program implemented on all 14 inpatient units with smoking educator support
Clinical education delivered:

1. Smoking cessation education for clinical staff on all units (300+ staff)
2. 12 clinical staff attended all day OMSC workshop
3. 4 staff attended the OMSC national conference in Ottawa - Feb 2013
4. 4 staff trained in CAMH’s Training Enhancement in Applied Cessation Counselling and Health (TEACH) program
5. Medical Grand Rounds delivered by Dr Andrew Pipe to all Physicians
6. Toronto Public Health & Smokers’ Helpline presentations on community supports and services for patients and staff

Over 107 patients offered nicotine dependence treatment - with an overall average of 39 years of smoking 18 cigarettes/day

Smoking cessation program indicators added to 2013-14 Quality Improvement Plan (QIP), submitted to Health Quality Ontario

Patient outcome data and measurement is ongoing, and uptake of the program is very positive so far—13% of recent new admissions were identified as smokers and have been offered the OMSC program. There are a number of challenges to obtain post discharge quit rates for complex patients, as only 20% agree to telephone follow up in the community. Many patients either do not want any follow up, or do not have or may not know a current telephone number prior to discharge. Baseline tobacco use survey data suggested that 19% of our Stroke & Neurological Rehabilitative Care patients have used tobacco within the last 6 months and have been smoking for an average of 40 years.

Phase 2 - Demonstration Project:
Stroke & Neurological Rehabilitative Care Units (Dec 2012 - ongoing)

Bridgepoint is one of fifteen Ontario hospitals that received 2-year Demonstration Project funding ($100K total) from the Ministry of Health and Long-Term Care in Sept 2012 for smoking cessation program implementation and enhancements in a complex care setting. Bridgepoint’s innovative Demonstration Project includes smoking cessation training and education for staff on the Stroke units, skills training for clinical staff to develop competencies in supporting patient health behaviour change and self-management, increased cessation support for patients, and funding to hire a smoking educator to further support individual and group smoking cessation counselling.

Bridgepoint Hospital is an ideal setting to examine the impact of comprehensive tobacco cessation on a complex patient population for a number of reasons, including:

- Patients are in our care for longer hospital stays than at acute care facilities (complex stroke rehabilitation average length of stay is 42 days).
- Most of our tobacco users have stopped their tobacco use while in acute care, and de facto have not been smoking for a period of time when they arrive at our doors.
- Bridgepoint has trained “Choices & Changes: Clinician Influence and Patient Action” Faculty on staff, as well as clinical staff with health coaching expertise to deliver & reinforce evidence-based health behaviour change/health communications curriculum

There are a number of modifiable risk factors for stroke and quitting smoking is one of the most important health behaviour changes to prevent a future stroke. Smoking cessation reduces recurrence of another stroke by fifty percent. 77% of smokers on our Stroke units to date said that they want to quit during this hospitalization (21 of 27).
The Demonstration Project supports clinical staff on the Stroke Units and in Ambulatory Care to attend an accredited health communication skill-building workshop. ‘Choices & Changes’ is based on theories of education, communication, the Stages of Change Model, Social Cognitive Theory, Self-Efficacy Theory, Self-Determination Theory, Motivational Interviewing, and the Conviction & Confidence Model. Participants learn specific strategies & skills to apply these models in a clinical care setting to support changes in health behavior and to provide self-management support to their patients, including smoking cessation.

Next steps:

- Continue to deliver and reinforce interprofessional best practice smoking cessation education and care on Stroke & Neurological Rehabilitative Care units
- Implement process improvements identified by teams, as well as make the documentation and referral processes electronic this fiscal year
- Build on the “Choices and Changes” workshop curriculum to develop a ‘Community of Practice’ for health coaching skills with Stroke unit clinicians
- Establish a professional-led peer smoking cessation education & support group for patients
- Continue to evaluate the impact of the OMSC and Demo Project on clinical practice, clinicians’ attitudes and skills, and patients’ participation in the OMSC program

Results to date:

✓ Pre-implementation staff surveys- baseline opinions and views regarding hospital based smoking cessation services
✓ Pre-workshop Clinician-Patient Communication surveys conducted to measure clinician’s attitudes and knowledge towards health behavior change
✓ 46 full-time and part-time Stroke unit & Ambulatory Care staff attended full day ‘Choices & Changes’ workshop
✓ 2 day/week Smoking Educator hired to support OMSC program
✓ Self-identified skills and techniques to support patient-centered health behavior change by workshop participants for ongoing community of practice development (E.g. reflective listening, asking patients before giving advice, building rapport, etc.)
✓ Positive testimonials, qualitative and quantitative results from workshop evaluations

Knowledge Translation & Dissemination – Presentations

- Toronto’s Tobacco Control Area Network meeting- Jan 2013
- 5th Annual OMSC national conference- Plenary speaker - Feb 2013
- Consultation with Toronto Public Health re: Smoking by-law expansion- Mar 2013
- Hospital Collaborative on Marginalized Populations presentation (TC-LHIN)- Apr 2013
- Demonstration Project Community of Practice presentation - Jun 2013

Community Partnerships & Engagement

Throughout the implementation of the OMSC, the introduction of the demonstration project and the adoption of the ‘Choices & Changes curriculum, Bridgepoint has leveraged opportunities to establish relationships with other health care facilities and public agencies to work together to address common challenges associated with smoking cessation. Engagement of Toronto Public Health has increased awareness of smoking cessation supports not only for patients but for our staff who have shown an interest in quitting and has provided a forum for discussion for how we can best meet the needs of our unique patient population as they transition from our care. Communities of practice are enabling collective action to address challenges related to policy enforcement and access to free nicotine replacement post-discharge to support patients making a quit attempt in a successful transition to the
community. Bridgepoint has also taken an active role in supporting a recommendation to consider expansion of city smoking by-laws to include hospital properties. Bridgepoint recognizes the value in working together as a system to address complex health issues.

**Evaluator comments:**

With the move to the new facility, Bridgepoint Active Healthcare identified the opportunity to become smoke-free as a health promotion initiative. In 2011, a research project indicated that 21% of the patient population identified as smokers. Seventy percent of these patients wished to stop smoking. Research indicated that quit rates improve in the hospital stay setting. The Ottawa model for smoking cessation (OMSC) was adapted for use in a rehabilitation facility, piloted and introduced on all inpatient units including the stroke unit. An OMSC grant was awarded and a part-time educator was hired. Indicators were added to the Quality Improvement Plan (QIP). An evaluation of the patient program has been carried out, and is ongoing. Information has been gathered about the desire patients have to quit, and the difficulties they experience. Staff members report that they are more aware of the challenges faced by their smoking patients. Physicians are engaged in the project. A protocol for nicotine replacement therapy is in place. A smoking assessment form is placed on each patient's chart. The educator approaches all the patients identified as currently smoking or having smoked in the past six months. An offer to participate in counseling is made to those expressing a readiness to quit.

Challenges to the program have been identified by the team. One such challenge is the follow-up of patients who are trying to quit and using NRT, after discharge. Determining the number still trying to quit and using NRT at a point in time such as six months is difficult in a setting where many people decline to be followed after discharge. Completion of the paper assessment forms by staff is a challenge and has resulted in a workaround by the educator using the electronic information on the initial nursing assessment. Modification of this assessment form, which is fairly long, and the change in attitudes by staff about smoking may improve compliance with the assessment process. One of the “reflections” from implementation of the OMSC program noted the need to support staff with training to increase their skill level and confidence in talking with patients about behavior changes related to smoking cessation. The Phase 2 demonstration project funded by a ministry grant will coach staff through workshops and mentorship and emphasize patient centered goals and motivational interviewing techniques. This demonstration project is focused on the stroke unit. Goals have been set and 46 stroke team members have been trained. The “Choices and Changes” training is an indicator in the 2013-4 QIP. A tool has been selected to evaluate the success of the project in meeting its goals. Team members have indicated that they do feel more confidence in engaging with patients in behavior change strategies, and say as well that these skills are spilling over to other interactions with their patients and clients. It seems reasonable to believe that this engagement of the staff in helping patients deal with this chronic illness will be a major boost to the success of this program over the long term. The outpatient team has indicated an interest in training their staff in these techniques. Evaluation criteria and indicators are planned as a next step in this project.

**Transitions in Care from Inpatient to Outpatient Stroke Rehabilitation**

**Project description:**

According to the Canadian Best Practices Recommendations for Stroke Care (2010) “patients, families, and caregivers should be prepared for their transitions between care environments by being provided with information, education, training, emotional support, and community services specific to the transition they are undergoing.”

**Issue:** At Bridgepoint Active Health Care it was identified that there was no formal process to transition stroke patients from the inpatient stroke program to the outpatient program resulting in access delays to outpatient services, a disruption to rehabilitation for patients upon discharge and a lack of structure
to support continuity of care among health care professionals. These service delivery challenges were occurring at a transition in care that inherently increases patient risk and at a time where patients and families often feel extremely vulnerable.

**Background:** All patients who have had a recent stroke and are admitted to the inpatient program are offered the opportunity and encouraged to attend the outpatient program as they transition from hospital to community. After careful review of current processes it became clear that there was no formal mechanism to support the transition of patients post discharge into the outpatient program. In addition, it was identified that there was no direct verbal communication between the inpatient therapists and outpatient therapists. Outpatient clinicians were primarily relying on discharge notes documented in the electronic medical record. Compounding issues were the wait times for patients to access outpatient services. Referrals for outpatient therapy by inpatient teams were submitted within days of discharge creating barriers to timely access to care as the volume of referrals could not be accommodated with short notice. Simultaneously, inpatient clinicians were unaware of the potential outpatient wait times experienced by patients following discharge and were therefore unable to manage patient expectations and implement temporary measures required to adequately address the gap in care.

**Project:** To ensure coordination and continuity of care representatives from outpatients met with the inpatient interprofessional team to identify opportunities to enhance the outpatient experience. The result was the implementation of a multi-pronged ‘transitions in care’ pilot project. The pilot project process includes the following elements:

1. A process to alert the outpatient program to a potential stroke patient referral early in the inpatient rehabilitation care plan. The “**Request for Waitlist**” completed by the inpatient therapist provides basic information that allows the outpatient team to place a hold in the outpatient therapy schedules for the patient based on the patient’s anticipated discharge date and care needs.

2. Once a discharge date is established and it is determined that the patient is appropriate for the outpatient program, a more comprehensive “**Internal Referral**” is completed by the inpatient care team. The referral is forwarded to outpatients to confirm the booking of the first appointment. Having an appointment prior to discharge ensures timely access to outpatient services and alleviates some of the anxiety experienced by patients and families during the transition from hospital to the community. Receiving a more comprehensive referral with a pre-established appointment time allows outpatient clinicians an opportunity to review the information and verbally consult with the inpatient team as necessary in preparation for the initiation of outpatient care.

3. An **orientation program** was implemented in early 2013 with the inpatient program to support the patient transition to ambulatory care. The orientation program is offered twice a week. Inpatient therapists identify eligible patients who are scheduled for discharge each week and notify the case manager in outpatients. Patients are directed to attend the designated sessions and can participate individually or as a group.

   Orientation includes an introduction to the outpatient program, a review of services provided, what to expect in the program and a detailed tour of the department. At the time of the orientation patients are either given a schedule for their first outpatient visit or shortly thereafter they will receive an appointment for admission to the outpatient program.
To support the efficiency and sustainability of the orientation program, volunteers have been trained to deliver the orientation program and physically support patients to tour the outpatient clinic.

**Evaluation:** A review of time from inpatient discharge to initial outpatient visit is underway. It is anticipated that wait times for initial outpatient assessments have improved with a goal to initiate outpatient service within one week of discharge.

Implementation of more structured length of stay targets by RPG has helped inpatient therapists better anticipate the timelines for discharge and facilitated earlier coordination of outpatient services.

Patients verbally report a positive experience with the orientation program, identifying that becoming familiar with the outpatient program, meeting therapists and hearing what to expect during their stay enhanced their expectation on admission to the outpatient program. Therapists reported that there were some challenges of ensuring patients were available and able to participate in orientation. As a result the outpatient program offered one-on-one sessions to those patients who were not able to participate in the group orientation.

Future plans, include ongoing assessment of patient’s perspectives and feedback as we strive for continuous quality improvement our patient care transitions from inpatients to outpatients. Development of a patient satisfaction survey and collection of data will provide additional information to inform this process and ensure sustainably of the project. Additional opportunities will be explored to enhance communication amongst the interprofessional teams and to foster increased integration of inpatient and outpatient programming for stroke.

**Evaluator comments:**

This creative project was developed after team members noted that patients felt very uncertain and anxious about the transition from inpatient to outpatient rehabilitation at Bridgepoint Active Healthcare. Patients expressed their desire to become familiar with the outpatient area prior to discharge. Staff members found they were spending much time orienting patients and responding to their concerns over the phone and on their initial visits to the ambulatory care area. The team identified an opportunity to improve this transition to outpatient care by orienting the patient and family prior to discharge. This project was developed to achieve this goal. The pilot commenced last winter. Patients identified by their therapist(s) and their caregivers are given a tour of the outpatient area they will attend. Efforts are made to schedule an initial outpatient assessment date prior to discharge. This innovation has not yet been formally evaluated. However a number of positive indicators noted by the team suggest that it will be successful in improving the transition of these patients to the outpatient setting. An improvement in patient knowledge about the plans for this transition has reduced anxiety which has been noted by the therapists. They stated that they believe that efficiency has improved. A reduction in wait time for the outpatient service has been noted in some cases. The process allows the patient to meet the new team and be familiar with the new environment prior to discharge. Evaluation measures are suggested, including patient and caregiver satisfaction, a reduction in anxiety and concern during the transition phase, and efficiency and effectiveness of the transition, perhaps including an improvement in wait times. The team is encouraged to continue this project and evaluate its effectiveness. Patient and caregiver involvement in the implementation and maintenance of this initiative may well be very helpful in maximizing the benefits to the organization and those it serves. A target of access to outpatient services within a week of discharge will be measured. A volunteer program to support this initiative is underway.
Evaluation of this creative initiative is encouraged. Patient and staff satisfaction will be other useful measures of its success.
Client and Family Education about Stroke

Client, family and caregiver education is an integral part of stroke care that should be addressed at all stages across the continuum of stroke care. In order to achieve Stroke Services Distinction, the following targets for providing client and family education that is an integrated component of stroke care and is consistently documented must be met.

Evaluator comments:

Education is reinforced with patients and families all the way through the rehabilitation process by all team members. Education regarding discharge begins early after admission and is documented. Translation services are available and used by the team when needed. The evaluators were provided with examples of strategies to communicate with patients with aphasia. Patient and family education is a strong focus of both the stroke team and the organization. As well, the organization is committed to and supports continuing education for its staff. This commitment and practice is a real strength of this organization.
Stroke Services Protocols

Implementation of stroke protocols is a key component of excellence in stroke services. Using protocols helps stroke services remain consistent, high quality, and evidence based. Accreditation Canada supports excellence by identifying stroke protocols that are in place to achieve Stroke Distinction.

Evaluator comments:

Swallowing assessment is performed within eight hours of admission on all patients. This is a screening assessment done by the speech language pathologist (SLP). It most often includes a review of previous assessments from the referring hospital and is augmented by further investigation if the screen suggests the patient has swallowing difficulties or is at risk for aspiration. Over the six month audit period, 59 of 60 stroke patients admitted to inpatient stroke rehabilitation received this screening. There is a question on the initial nursing assessment which asks about swallowing difficulties and can trigger a referral. The quick response by an SLP is to some degree due to the admission practices of the organization, which occurs five days a week. The evaluators were made aware of a provincial QBP initiative to encourage seven day a week admissions. Should this occur, a change in practice to meet this important criterion would be required. The initial assessment of rehabilitation needs was assessed, with no concerns found. Medication reconciliation at admission is done by the pharmacy team on all patients. The management of diabetes is meeting the standards for stroke patients. No concerns were identified.
Performance Measures

The following section provides a comparison of the performance measures (indicators) collected for stroke services and the measures collected nationally.

Core Performance Indicator Results - Inpatient Rehabilitation Services

Below are the results from core performance indicators. Overall performance is based on data submitted by the organization for each indicator.

Proportion of clients treated on stroke unit (inpatient rehabilitation)

Numerator: # of stroke clients admitted to hospital and treated in an inpatient rehab stroke unit at any time during hospital stay

Denominator: Total # of stroke clients admitted to a hospital (TIA, ischemic, hemorrhage)

Length of stay in an inpatient rehabilitation setting for patients admitted following an acute stroke event

Numerator: Total number of days for all stroke patients admitted to an inpatient rehabilitation setting following an acute stroke event and discharged alive

Denominator: Total # of stroke patients discharged alive from an inpatient rehabilitation setting
Proportion of clients prescribed antithrombotic therapy (inpatient rehabilitation)

Numerator: # of stroke/TIA who are discharged from the inpatient rehabilitation services on antithrombotic therapy

Denominator: Total # of ischemic / TIA stroke clients discharged from inpatient rehabilitation

Proportion of clients with initial dysphagia screening at admission (inpatient rehabilitation)

Numerator: # of stroke clients who receive dysphagia screening in inpatient rehabilitation

Denominator: Total # of stroke clients admitted to inpatient rehabilitation
Next Steps

The organization is encouraged to use the findings in this report to prioritize areas for improvement. This is your opportunity to demonstrate a continued commitment to improving stroke services for clients and families.

As you know, Distinction requires an ongoing commitment to the highest levels of quality service. To maintain Distinction status, it is important to continue submitting performance indicator data in your portal. For additional information on submitting indicator data or on any other aspect of the program, contact your Accreditation Specialist.

Thank you for participating in the Stroke Services Distinction Program.
A Holistic Approach to Stroke Rehabilitation

2012-13 Overview of Bridgepoint Hospital’s Stroke Program
As a pioneer of active healthcare, Bridgepoint is transforming the way patients with complex health conditions receive their healthcare and lead their lives.

Putting best practices into action, we provide a rehabilitation process that is not only progressive, dynamic, and goal-oriented, but that shifts away from the old model of isolated treatments by multiple care providers toward a fully-integrated team that can collaborate across the continuum of care to optimize the individual’s potential for recovery.

Active healthcare puts the patient at the centre of their own care. By maintaining our focus on the whole person and empowering our patients to participate fully in their recovery, we work hard to support a seamless transition that gets them back to life in the community, which is where they belong.

Through groundbreaking research, outstanding care and a commitment to ongoing improvement and innovation, our goal is to be the leading provider of healthcare, community rehabilitation, wellness programs, education and research for patients with complex health conditions.

Bridgepoint Active Healthcare is made up of the Bridgepoint Hospital, Bridgepoint Family Health Team, Bridgepoint Collaboratory for Research and Innovation, and Bridgepoint Foundation.
Bridgepoint’s Leading Stroke Rehabilitation Program

Since the Ontario Stroke Strategy was created in 2000, Bridgepoint has been actively engaged in supporting stroke patients through treatment, education and access to rehab services. From our collaboration with the GTA Rehab Network which saw the creation of the "Rehab Finder" in 2004 to our current work on the MSK/Stroke Implementation Group to realign and improve stroke rehabilitation across the GTA, we continue to act as system partners to improve outcomes for the leading cause of adult disability in Ontario.

Bridgepoint was among the first in Ontario to operationalize best practices at the heart of our stroke program and optimize the patient experience to actively manage inpatient time at Bridgepoint. Our commitment to standards, clinical excellence and leadership in stroke care is closing the gap between knowledge and practice at Bridgepoint, allowing us to deliver consistent, high-quality and evidence-based programs that are significantly reducing the impact of stroke on our patients.

Our complete program is supported by ongoing research designed to explore how stroke rehabilitation clinicians conceptualize complexity and the use of best practice recommendations in treating patients.

Our specialty is delving into complexity and both simplifying and streamlining treatment. The entire care plan is important to us and this approach helps patients as they prepare to transition back to life outside of the hospital.

Our stroke patients are active partners with our interprofessional team to help support their rehabilitation and return home and to the community. Our robust ambulatory care program includes vocational rehabilitation and provides our patients with a seamless transition to outpatient programming.

This report highlights Bridgepoint’s holistic approach to stroke rehabilitation. This is evident from our integrated inpatient rehabilitation programs, to our unique 55 and under neuro-support program for stroke survivors and our support for staff through education programs such as “Choices and Changes”. 

A HOLISTIC APPROACH TO STROKE REHABILITATION
Stroke Program by the Numbers

100%
Proportion of clients treated on stroke unit (inpatient rehabilitation)

43 Days
Average length of stay in an inpatient rehabilitation setting for patients admitted following an acute stroke event

96%
Proportion of (eligible) clients prescribed antithrombotic therapy (inpatient rehabilitation)

98%
Proportion of clients with initial dysphagia screening at admission (inpatient rehabilitation)

29
Average change in functional status using a standardized measurement tool

92%
Proportion of stroke patients with documentation to indicate screening for depression

Number of admissions to High Intensity Stroke Program-5 year scan

Average Length of Stay in High Intensity Stroke Rehab

2012-13 Stroke Cases by Referral Source

- 26% Other
- 31% UHN
- 28% St. Michael’s Hospital
- 9% TECH
- 6% Sunnybrook
An Integrated Approach to Stroke Care

Our integrated stroke program offers both inpatient and outpatient rehabilitation services for patients who have experienced moderate to severe impairment resulting from a stroke. Together, these complimentary programs allow our team to tailor treatment to individual patient goals, abilities and progress across the continuum of care. The following chart outlines how stroke patients are supported across all four patient programs at Bridgepoint.

### High Intensity Stroke Care
- High intensity rehab program for patients who have experienced moderate to severe impairment resulting from a stroke
- Includes 180 min of therapy per day, 5 days a week (Occupational, Physio, Speech)
- 20 beds
- Average length of stay 6 weeks or less

### Reconditioning Stroke Care
- Lower intensity rehab program for patients who require a slower paced therapy program or who may require a longer LOS
- 28 beds
- Average length of stay 12 weeks or less

### Specialized Medical and Complex Care
- Designed for patients with significant health impairments who have finished a course of rehab or are not able to participate in a rehab program
- Emphasis on stabilization, health optimization, functional maintenance and risk reduction

### Outpatient Stroke Care
- Held at the Christine Sinclair Ambulatory Care center
- A short-term, intensive active rehab program
- Average duration 2 times a week for 8 weeks
- Includes therapy (group and individual), education and case management services

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#### TRANSITIONS IN CARE
- **ACUTE CARE**
- **INPATIENT**
- **OUTPATIENT**
- **COMMUNITY INTEGRATION**

#### ACTIVE PATIENT/FAMILY ENGAGEMENT
- **COMMUNITY INTEGRATION**
- **OUTPATIENT**
- **INPATIENT**
- **ACUTE CARE**
- **TRANSITIONS IN CARE**

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A HOLISTIC APPROACH TO STROKE REHABILITATION
An Integrated Team

Our stroke patients are supported by an interprofessional team of inpatient and outpatient physiotherapists, occupational therapists, nurses, physicians, physiatrists, social workers, speech language pathologists and recreation therapists who use best practices to help guide their treatment plans.

Patients recovering from a stroke at Bridgepoint have access to a wide variety of clinics and programs, including:

- Vocational rehabilitation
- Neuropsychology services
- Mindful Connections: A Young Stroke/Neuro Peer Support Group
- Augmentative Communication and Writing Clinic
- Seating Clinic
- Dental Clinic
- Spasticity Management Services
- Chiropody
- Ophthalmology
- Smoking Cessation
- Interpreter Services

In Focus: Mindful Connections

Bridgepoint’s Mindful Connections: Young Neuro Peer Support Group is designed for patients between the ages of 18 and 55 years old who are looking for mutual support and education following a neurological diagnosis, such as stroke, ABI, or neurodegenerative disease. The group is facilitated by the ambulatory care social worker, with guest speakers occasionally invited to attend.

Topics are guided by group interest and focus on aspects of psycho-social adjustment following a neurological event. They include: relationship changes, return to work, emotional/personality changes, anger management, acceptance/adjustment to disability, stress management, self-management, and community/social reintegration.

The group meets biweekly for approximately 16 weeks. Mindful Connections is open to active outpatients or those within 6 months of their discharge from our inpatient program.
From Wheelchair to Walker to Work

The day that Dale Herceg arrived at Bridgepoint Hospital in a wheelchair in January 2013, his care team asked him to consider one question: What are your goals? The answer to that question – which, for Dale, was to return to his family at home, his career, and his active workouts – was the first step in creating a care plan that would put him on the path to recovery after suffering a stroke that left him with double vision and no balance. After three weeks of intensive inpatient rehabilitation at Bridgepoint, Dale was discharged home and continued his therapy at Bridgepoint as an outpatient.

“Just having those goals was really important in giving me something to work towards,” recalls Dale, who, eight months later, has reached two of those three milestones and is well on his way to achieving the third.

A retired lawyer who now arbitrates disagreements between lawyers and clients, Dale admits that he asked his care team so many questions, they may have felt they were being cross-examined. “Every member of my care team at Bridgepoint – physiotherapists, occupational therapists, doctors, nurses, speech pathologists – I’ve felt a rapport with,” he says. “I know I’m self-motivated, but I’ve never felt like I was doing this myself.”

It’s admittedly been a rough road for Dale, though, and it included one major setback. Everything was progressing well until mid-May. Then, one morning, Dale’s wife of 34 years was unable to wake him. Rushed to hospital unconscious, Dale was diagnosed with ketoacidosis – a potentially fatal metabolic disorder that can affect diabetics.

After more than a week in acute care, Dale was once again discharged. The good news was that, thanks to intensive physiotherapy during his hospital stay, Dale had maintained or improved on the physical progress he’d made over the previous four months at Bridgepoint. After a summer of continued regular outpatient and occupational therapy at Bridgepoint, he achieved his second goal: returning to work.

“When I arrived at Bridgepoint in January, I was in a wheelchair, and I was scared,” Dale recalls. “I’ll never forget the porter who took me to my first physio session. He reassured me that he’d seen people achieve remarkable things at Bridgepoint. That really lifted me. When I was discharged in February, I was walking with a cane. I’m happy, fortunate and grateful – and I couldn’t have done it without Bridgepoint.”
Transitions in Care from Inpatient to Outpatient Stroke Rehabilitation

As the Canadian Best Practices Recommendations for Stroke Care makes clear, patients, families, and caregivers need to be prepared for their transitions between care environments, and that requires access to information, education, training, emotional support and community services.

All recent stroke patients who are admitted as inpatients to Bridgepoint are encouraged to attend our comprehensive ambulatory care program to support their successful transition from our hospital back to the community. As part of our ongoing program improvement efforts, however, a recent review of current processes revealed that there was no formal mechanism to support the transition of patients post-discharge into the outpatient program.

To fill this gap in the continuity of care, representatives from our outpatient and inpatient teams met to identify opportunities to enhance the outpatient experience. The result was the implementation of a ‘transitions in care’ pilot project.

Implemented in early 2013, this orientation program aims at facilitating patient transitions into ambulatory care. Toward that end, our inpatient therapists are identifying eligible patients who are scheduled for discharge each week and notifying the case manager in ambulatory care. Eligible patients are then directed to attend designated orientation sessions held twice a week that they can participate in, either individually or as part of a group.

These sessions include an introduction to the outpatient stroke program, a review of services provided, what to expect in the program and a detailed tour of the department.

To support the sustainability of the program, volunteers have been trained to deliver these orientations and physically support patients in their tour of the outpatient clinic.

So far, informal feedback from our patients has been very positive. They have told us that becoming familiar with the outpatient program, meeting therapists and hearing what to expect during their stay at Bridgepoint has enhanced their confidence in the next stage of care prior to discharge and on admission to the outpatient program.

As we move forward with the pilot, we are in the process of designing a more formalized and ongoing assessment of patient feedback as we strive for continuous quality improvement in our patient care. Development of a patient satisfaction survey and collection of data will provide additional information to inform this process and ensure sustainability of the project. Additional opportunities will be explored to enhance communication amongst the interprofessional teams and to foster increased integration of inpatient and outpatient programming for stroke care.
The Bridgepoint Collaboratory for Research and Innovation is the only research facility in Canada – and among only a few worldwide – that is 100% focused on developing clinical evidence and best practice for treating patients with complex health conditions. Within it, the Stroke Rehabilitation and Multimorbidity program of research is led by Dr. Michelle Nelson whose interdisciplinary research team collaborates with our staff and external partners to put emerging, evidence-based knowledge to work to improve the lives of our patients.

To date, four key projects are underway that will advance both our understanding of stroke patients with complex health conditions and our clinical practices for treating them more effectively.

**CIHR Funded Project: October 2013 – September 2014**

Stroke Rehabilitation and Patients with Multimorbidity – A Scoping Review: Stroke care presents challenges for clinicians, as most strokes (roughly 80%) occur in combination with other serious medical diagnoses. The purpose of this scoping review is to document the extent to which multimorbidity is included in stroke rehabilitation evidence, and identify the associated gaps in the evidence pertaining to rehabilitation for these patients.
Complexity in Clinical Practice
This exploratory study examined how stroke rehabilitation clinicians perceive patient complexity and the influence it has on their clinical practice (including the use of best practice recommendations). Clinical team members confirmed that patients in inpatient stroke units are very medically and socially complex, which influences their ability to benefit from rehabilitation. Indeed, the defining characteristic of complexity was whether or not a patient could be discharged. Clinicians questioned how applicable the current recommendations are for these patients whom they frequently see in their daily practice. Instead, clinicians reported primarily relying on their sound clinical judgement, teamwork, and creativity to address the rehabilitation needs of these complex patients.

Appraisal of the Best Practice Recommendations
Stroke care in Canada is being transformed to align with the existing Best Practice Guidelines. But if most stroke patients have other co-occurring conditions, the question arises whether current recommendations are sufficient to specifically address this population. In response, we are conducting an appraisal of the recommendations regarding management of multimorbidity and any treatment guidance and/or contraindications noted.

Building a Multimorbidity Profile of Stroke Rehabilitation Patients
Although there is data regarding comorbidity/multimorbidity and the stroke patient population, the reports typically reflect the risk factor profile of patients (diabetes, hypertension, hyperlipidemia, obesity, and smoking). This project, conducted in collaboration with the Institute of Clinical Evaluative Sciences provides a unique opportunity to examine multimorbidity data (Charlson Comorbidity Index and risk factors) collected for all stroke patients in Ontario to delineate patient characteristics and create a ‘persona’ (case style presentation) of multimorbidity and stroke.
Education Programs

Education is an integral part of our stroke program at Bridgepoint, and one that we address across the continuum of care, for both patients and staff alike. We know that this is vital to the efficacy of our programs, the clinical excellence of our teams, and, most importantly, the experience of our patients whose progress and transition back in to community benefits immensely from the insights and strategies that these programs impart. As always, the goal is ongoing improvement of our protocols and practices, which relies heavily on our highly effective collaborative team approach.

Patient Safety Education Program

In 2010, Bridgepoint became the first Canadian adopter of the Canadian Patient Safety Institute’s (CPSI) Patient Safety Education Program (PSEP) and was given their inaugural award for innovation in this critical area of patient care. To date, we have delivered the six-month course, which combines 32 hours of classroom learning with group project work, to 81 of our staff members. On both occasions that the PSEP has been offered so far, staff from both the neurological inpatient and ambulatory care programs indicated their appreciation for what they described as a unique opportunity to collaborate on a quality improvement project that supports the safe transition of stroke patients from an inpatient setting to outpatients.

License to Drive

We know that a return to driving is a critical concern and goal for many of our stroke patients, so when an evaluation of our patient documentation revealed that driver status information was missing from over half of our patient files in our outpatient program, we moved quickly to address this gap. In doing so, our License to Drive project team chose to focus on mapping the driving status process at Bridgepoint Hospital and identifying the gaps in communication between the inpatient and outpatient programs.

Using PDSA (Plan, Do, Study, Act) cycles, the project team determined that driving status should ideally be documented in the Physiatry family meeting notes or documented during interprofessional clinical rounds. They recommended a consistent process for recording and communicating a patient’s driving status among team members, the patient and his/her family. Early audits and evaluation revealed a 30% increase in the consistency of where and how patient driving status was communicated across interprofessional teams.

A one-page information sheet was also developed by clinicians and physicians to support patient education in this area.
Glucometer Training
The inpatient stroke and ambulatory care interprofessional teams identified barriers to safe discharge planning when their patients were not adequately trained on the proper use of a glucometer by their discharge date.

The culprit, the team determined, was that there was no consistent process for identifying patients requiring glucometer training and some internal discrepancy regarding who is responsible for the training process. The need for interdisciplinary collaboration was clear.

Using the PDSA approach, they introduced a modified rounds template that added glucometer training as a discussion item so that relevant patients would be identified and team input could be obtained on potential barriers to be addressed for successful training prior to discharge.

In addition, questionnaires were administered to patients to determine their understanding and comfort level with using a glucometer, prior to discharge. Upon their admission to ambulatory care, questionnaires were re-administered to the same patients to assess their management of the glucometer in the community.

As a result of this effort, we now have a more effective and modified ambulatory care referral form to incorporate glucometer training, which is an important piece in enabling diabetes self-management in stroke patients.

“Choices & Changes” – Empowering Clinicians to Support Changes in Health Behavior

Among smokers who have suffered a stroke, quitting the habit is one of the most effective changes they can make to prevent a future stroke, reducing the likelihood of recurrence by 50%. According to the Canadian Best Practice Guidelines for Stroke, “All members of the interdisciplinary team should address smoking cessation and a smoke-free environment at every healthcare encounter for active smokers”. When asked, four out of five Bridgepoint patients who smoke say they think it is important for them to quit, and over 62% of smokers express a desire to quit during their hospital stay (over 75% on our Stroke & Neurological Care units).

In September 2012, Bridgepoint was one of fifteen Ontario hospitals to receive a 2-year Demonstration Project funding from the Ministry of Health and Long-Term Care for smoking cessation program implementation and enhancements in a complex care setting. Bridgepoint’s project includes smoking cessation training and education for staff in the stroke program, as well as increased cessation support for patients, and funding to hire a smoking educator to further support individual and group smoking cessation counseling.

The project enables clinical staff in the inpatient and outpatient stroke programs to attend an accredited health communication skill-building workshop, ‘Choices & Changes’ is based on the latest theories of education and communication regarding health behaviour change, including the Stages of Change Model, Social Cognitive Theory,
Self-Efficacy Theory, Self-Determination Theory, Motivational Interviewing, and the Conviction & Confidence Model. Participants learn specific strategies and skills to apply in a clinical care setting to support changes in health behaviour, such as smoking cessation, and to provide self-management support to their patients.

Results to date:

• 46 staff have attended a full day ‘Choices & Changes’ workshop

• Positive results (both qualitative and quantitative) from workshop evaluations strongly support the value of this program to participants who report a marked improvement in their skills and techniques to support and encourage patient-centred health behaviour change

Building on these successes, planned next steps for the program include:

• Implementation of process improvements identified by teams, as well as making the documentation and referral processes electronic

• Building on the “Choices and Changes” workshop curriculum to develop a ‘Community of Practice’ for health coaching skills with Stroke unit clinicians

• Establishing a professional-led peer smoking cessation education group for patients

• Continuing to evaluate the impact of the OMSC and Demo Project on clinical practice, clinicians’ attitudes and skills, and patients’ participation in the OMSC program

Dale Mackey, right with LiveWell! Strategy Lead Susan Himel.

Dale Mackey Smoking Cessation Educator

Dale Mackey has practiced Health Science and Respiratory Health for 28 years. She obtained her B.Sc. from University of Waterloo, and is a licensed Registered Respiratory Therapist with the College of Respiratory Therapists of Ontario, as well as a Certified Asthma Educator, COPD Educator, Nicotine Dependency Specialist and Smoking Cessation Specialist.

Dale has supported special populations and programs using Smoking Cessation best practice guidelines, evidence-based education, motivational interviewing and behavioral modification. In 2012, Dale joined Bridgepoint Active Healthcare’s LiveWell! program, working with complex rehabilitation and chronic care patients.
The Stroke Rehabilitation Team

Michael Calvert, RN, Patient Care Manager
Michael holds a Bachelor of Science in Nursing from Ryerson University. He has worked on the neurological rehabilitation unit at Bridgepoint since 2001, first as a nurse clinician responsible for ongoing staff and patient education, then, since 2005, as a Patient Care Manager for the complex neurological rehabilitation units. During his time as Interim Director of Rehabilitation and Activation services (2010-13), Michael implemented Stroke Best Practice Guideline Initiatives. He is a member of the Southeast Toronto Stroke Network and serves as a chair of Bridgepoint’s Rehabilitation Services Program Council.

Melissa Cutler, Social Worker
Melissa holds a Master of Arts in Psychology and a Master of Social Work from the University of Toronto. She is a current member of the Brain Injury Society of Toronto, the Canadian Association of Social Workers, and the Internal Network of Social Workers in Acquired Brain Injury. She has practiced for over 12 years in the field of neuro-rehabilitation. Melissa’s particular area of interest is the psychosocial experience of young neuro survivors, for whom she has developed and facilitated peer support groups for the last two years. Currently, she is conducting a qualitative study to measure group effectiveness on survivor psychosocial adjustment post event and presented preliminary findings at the 2010 South East Toronto Stroke Network conference on Chronic Disease Management and Stroke.

Sandy Duncan, Occupational Therapist
Sandy is an honors graduate of the Occupational Therapy, Bachelor of Science program at the University of Toronto who has 18 years of professional experience. She is a member of the College of Occupational Therapists of Ontario and the Ontario Society of Occupational Therapists. Sandy joined Bridgepoint in 1996 and for the past 6 years has also functioned in the role of Clinical Practice Leader - Occupational Therapy service. She has taken a number of continuing education courses related to stroke rehabilitation, such as Motor Relearning Program, NDT – Introduction and 3 week courses, CMSA course, Unilateral Spatial Neglect workshop, Apraxia symposium, and stroke in young adults.

Shauna Hurnanen, Physiotherapist
Shauna has a Bachelor’s of Kinesiology from McMaster University and a Bachelor’s of Physical Therapy from the University of Toronto. She has practiced for 10 years in the area of stroke and neurological rehabilitation and is currently a member of the Toronto Stroke Networks Cross-system Knowledge Translation & Implementation Committee for Best Practices. Shauna is a certified NDT therapist and has completed advanced NDT training in upper extremity function and gait, as well as being trained in the Chedoke McMaster Stroke Assessment. Shauna has completed the University of Toronto Educating Heath Professionals for Interprofessional Care course and the Bridgepoint Patient Safety Education Project. She holds a status-only appointment of lecturer with the University of Toronto Physical Therapy Department.

Marie Kranz, RN
Marie graduated in 1985 and worked for 8 years in a university hospital in Germany before immigrating to Canada. She has worked at Bridgepoint since 1999 and in the neuro-rehabilitation program since 2007.

In 2010, Marie earned a Certificate in Neuroscience Nursing at George Brown College in conjunction with St. Michael’s Hospital. Currently, she is actively involved in a research project on timely education for stroke survivors in transition of care.
A Holistic Approach to Stroke Rehabilitation

Heather MacNeill, MD, BSc (PT), MScCh (HPTE), FRCPC
Heather originally worked as a physiotherapist specializing in stroke, with NDT training. She obtained her medical degree at Queen’s and completed her residency in Physical Medicine and Rehabilitation at University of Toronto. She has been practicing at Bridgepoint since 2006 with further training in spasticity management and the use of injectable botulism toxin. Heather is the Director of Medical Education at Bridgepoint and an Assistant Professor at the University of Toronto, Department of Medicine. She is currently working with the stroke teams to create a remodeled education program integrating peer and transitional support for patients and families of stroke survivors. She is the Principal Investigator on a qualitative study examining stroke survivor’s educational needs as they transition from inpatient to outpatient and to the community.

Robin Mowforth, Communications Disorders Assistant
Robin has a BA in Linguistics from York University and certification as a Communicative Disorders Assistant from Georgian College. She has worked at Bridgepoint Hospital in Neurological Rehabilitation with both inpatients and outpatients for the past 8 years. Robin has taken several continuous education/learning courses, including: the Supported Communication for Aphasia course from the Aphasia Institute; Practices in Stroke Rehabilitation for Assistants through Humber College; education sessions in Community Re-engagement Research; and Stroke Best Practice Chronic Disease Management and Stroke: Stroke and the Young Adult. She currently runs a hospital-wide aphasia group that serves people with low to moderate levels of aphasia.

Lynn Race-Head, Occupational Therapist, Vocational Rehab
Lynne Race-Head is a graduate of University of Toronto Occupational Therapy program. She has focused her career on enabling patients to improve their community productivity and is the only therapist in the GTA offering vocational services to OHIP clients. Lynne has worked with clients with work-related injuries, low vision and blindness, and those wanting to return to work, school or volunteering post-stroke and acquired brain injury. She has worked at Bridgepoint since 2006 in the position of occupational therapist with the ambulatory care vocational program. She is General Aptitude Test Battery certified and is proficient with a number of other standardized work-related and cognitive assessments.

Tammy Sieminowski, MD, CCFP, MEng
Tammy has been an attending physician for the neuro-rehabilitation program at Bridgepoint since 2002. She completed her medical degree and residency training at the University of Toronto, Department of Family and Community Medicine. Her research interests include interdisciplinary team processes and how these impact quality of patient care and health system resource management. She is the Principle Investigator for the Neuro-rehabilitation Registry at Bridgepoint which collects metrics that facilitate research and continuous quality improvement on the neuro-rehabilitation units. She is a Lecturer in the Faculty of Medicine at the University of Toronto and a clinical supervisor/co-investigator working with undergraduate and graduate students in the Faculty of Engineering.

Ryan Wood, Speech-Language Pathologist
Ryan holds a Bachelor of Science from McGill University and Masters in Health Sciences from University of Toronto. Since starting in 2009, Ryan’s work at Bridgepoint has focused on the neuro population where he has had the opportunity to work in both high intensity and reconditioning programs. Ryan has provided ongoing education to staff, families and students regarding safe swallowing practices and communication strategies and is currently assisting with the development of a stroke education series for in– and outpatient populations. Ryan is a certified member of the Canadian Association of Speech-Language Pathologists and Audiologists.
**INVESTING IN COMPREHENSIVE STROKE REHAB SERVICES**

1.0 The site collects and analyzes information about the need for inpatient stroke rehabilitation services.

1.1 Site annually collects information about stroke incidence in the population it serves. Incidence includes proportion of ischemic strokes, TIA’s and hemorrhagic strokes. Site considers provincial and national stroke rates to add context to their information about proportion of stroke cases.

**High**
- **Target:** 90%

**Low**
- **Target:** 75%

## Bridgepoint Health – Stroke Distinction—Standards for Inpatient Stroke Rehabilitation

<table>
<thead>
<tr>
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<tr>
<td>1.3</td>
<td>Low</td>
<td>site collects demographic information about high risk and hard to reach populations</td>
<td>may include information about • ethnicity, • culture, • age or • gender. • High risk populations identified as at increased risk of stroke based on their characteristics (e.g., presence of hypertension). • Hard to reach include remote &amp; rural areas, • minority groups, • hidden populations (drug users) or people with disabilities. • Hard to reach populations are identified by the organization based on the population they serve</td>
<td>Red</td>
<td></td>
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<tr>
<td>1.4</td>
<td>Low</td>
<td>site uses information about demand for inpatient rehab services to identify and analyze barriers that prevent access to services</td>
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### ENGAGING A PREPARED AND PROACTIVE REHAB TEAM

2.0 Stroke rehab team uses an interdisciplinary approach to coordinate and deliver inpatient rehab services

| 2.1      | High     | The team has expertise in stroke care and uses an interprofessional approach to deliver inpatient stroke rehabilitation services to clients and families. | primary members of team include: patient, family, • physiatrist, • nurses, • PT, • OT, • SLP, • SW, • dietician, • pharmacist Additional members: • pastoral care, • recreation therapist, • rehab assts, • psychologist | Green | | |
| 2.2      | Low      | The team has clearly defined roles and responsibilities in delivering stroke services | | | | |
| 2.3      | Low      | Each team member has the necessary credentials or license from the appropriate professional college or association. | team has a process to verify that credentials or licenses are appropriate and up-to-date. | | | |
| 2.4      | Low      | The team orients new staff and service providers about the unique aspects of stroke rehabilitation services. | orientation includes: • specific nature of interprofessional stroke rehab services, • linkages with acute services, • home and community services, long term care. • Orientation also includes causes of stroke; • risk factors management; • complications of stroke including depression, spasticity/flaccidity, aphasia, and dysphagia; and • protocols for stroke rehabilitation services. | | | |
| 2.5      | Low      | The team receives ongoing professional development and training to deliver current evidence-based stroke rehabilitation services. | Training may include access to and review of the latest research, guidelines, and practice changes. • Team members have opportunities to attend in-services and conferences on stroke management. | | | |
| 2.6      | Low      | The team uses information from staff performance evaluations to improve stroke rehabilitation services, and identify support, training, or development needs for the team. | | | |
Bridgepoint Health -- Stroke Distinction--Standards for Inpatient Stroke Rehabilitation

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<td>2.7</td>
<td>Low</td>
<td>The team has adopted and implemented the Canadian Best Practice Recommendations for Stroke Care (Canadian Stroke Strategy) for the assessment and management of patients.</td>
<td>Using national guidelines help to increase standardization and consistency of stroke services for all stroke clients regardless of location. The team may need to adapt the guidelines based on available resources; however, the national guidelines should be considered the reference standard for stroke service provision and teams should strive to meet as many of these standards as possible within their available resources.</td>
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<tr>
<td>3.0</td>
<td>Interdisciplinary team providing inpatient stroke rehab has support from leadership &amp; resources to provide effective services</td>
<td></td>
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<tr>
<td>3.1</td>
<td>High</td>
<td>The interprofessional team providing inpatient stroke rehab has a designated coordinator.</td>
<td>Coordinators for stroke services may be an individual (e.g. clinical department head) or a group (e.g. advisory board). The site may also invest in leadership development to keep stroke coordinators engaged in planning for stroke services.</td>
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<td>3.2</td>
<td>Low</td>
<td>The team works with staff, other service providers, community partners to develop goals and objectives for stroke rehab services that are aligned with the site’s strategic and operational plans.</td>
<td>Goals and objectives describe what the site wants to achieve for stroke services, how to achieve it through partnerships by linking the stroke team’s goals and objectives to the site’s strategic direction. Staff and service providers have input into the development of specific team goals and objectives to accomplish high quality stroke rehab service delivery. Community partners, patients, and families should be involved in developing stroke team goals and objectives.</td>
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<tr>
<td>3.3</td>
<td>Low</td>
<td>Goals and objectives for stroke rehabilitation services are specific and measurable.</td>
<td>Provide realistic, time-specific, and measurable goals and objectives is a success factor to achieving outcomes for stroke rehabilitation services.</td>
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<tr>
<td>3.4</td>
<td>High</td>
<td>The team has resources to establish and support dedicated stroke units for inpatient stroke rehab services.</td>
<td>A stroke unit is a geographically discrete area with beds designated for stroke clients who consistently receive services from an interprofessional stroke team. Best practice evidence demonstrates that geographically discrete stroke rehabilitation units improve outcomes.</td>
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<td>3.5</td>
<td>Low</td>
<td>The layout of the physical space contributes to the effectiveness and safety of stroke services.</td>
<td>The layout of physical space can contribute to the effectiveness of delivering stroke services, e.g. locating services in close proximity to minimize distances between services for clients, and designing service areas to help service providers monitor clients.</td>
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<tr>
<td>3.6</td>
<td>Low</td>
<td>The team uses telehealth to increase access to stroke specialists.</td>
<td>Telehealth, or telestroke, includes the use of telecommunication technologies to link referring and consulting health care sites for the purpose of real-time assessment and management of patients with stroke. •Telephone, web-based video archives and video communication act as links between two or more settings. •Telestroke is used where resource or distance issues prevent equitable access to evidence-based stroke services. •For example, telestroke is used by stroke rehabilitation clients for pre-rehabilitation admission assessment, to access exercise classes, speech-language services, and other assessments that are not available at the client’s home health care facility. •Telestroke also provides a mechanism for increasing access to stroke expertise and education in the post-acute period, focusing on secondary prevention, rehab and recovery.</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>Low</td>
<td>When delivering stroke services, the team has access to equipment and supplies appropriate to the needs of the stroke clients and the population it serves.</td>
<td>Equipment and supplies include functional electric stimulation, treadmills, accessible washrooms, and adequate wheelchairs.</td>
<td>Red</td>
<td></td>
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<tr>
<td>4.0</td>
<td>Low</td>
<td>The team collaborates with acute stroke services, inpatient rehab services, programs and providers within their site to coordinate rehab services for stroke clients.</td>
<td>The site may share resources and services to enhance the efficiency and effectiveness of inpatient rehab services for stroke clients.</td>
<td>Red</td>
<td></td>
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<tr>
<td>4.1</td>
<td>High</td>
<td>The team collaborates with acute stroke services, inpatient rehab services, programs and providers within their site to coordinate rehab services for stroke clients.</td>
<td>The site may share resources and services to enhance the efficiency and effectiveness of inpatient rehab services for stroke clients.</td>
<td>Yellow</td>
<td></td>
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<tr>
<td>4.2</td>
<td>Low</td>
<td>The team collaborates with acute hospitals, other rehab sites, primary care practitioners, long-term care, home care, and community-based services to coordinate and plan inpatient rehab services in the site’s service boundary.</td>
<td>Stroke clients enter inpatient rehab services from a variety of settings. •Coordinating and planning stroke rehab services includes client flow, linkages across the continuum, expected roles and responsibilities, and stroke prevention and client education strategies across the continuum. •Other partnerships may include home-based services and outpatient services, such as exercise programs and support groups.</td>
<td>Yellow</td>
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<tr>
<td>4.3</td>
<td>Low</td>
<td>The team works with community agencies to sponsor public campaigns to raise awareness about stroke rehab services available in the community, the impact of stroke, and living with stroke.</td>
<td>Public campaigns create appropriate and consistent messaging about the impact and consequences of stroke and raise awareness about services in the community. •Services include community, rehab programs, outreach and community action programs, stroke survivor groups, and caregiver support groups.</td>
<td>Yellow</td>
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### PROVIDING SAFE AND APPROPRIATE INPT REHAB SERVICES

5.0 The team coordinates timely access to inpatient rehab services for clients and families and caregivers, service providers, and referring organizations.

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<tr>
<td>5.1</td>
<td>High</td>
<td>The team has formal intake criteria and processes based on standardized assessments.</td>
<td>Intake may also be called admission, pre-admission, or screening. • Intake criteria and processes are clearly defined and based on standardized assessment information and scores. • Intake is used to guide whether or not the team’s services fit with the client’s needs and preferences, identify the client’s immediate needs, and decide on service priorities. • The process is adjusted for clients and families with diverse needs (e.g., language, culture, education, level of disability).</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Low</td>
<td>The team communicates referral processes and intake criteria for inpatient stroke rehab to all referring centres, including acute care providers, complex continuing care, long term care homes, home care services, as well as to clients and families.</td>
<td>Regular meetings or other forms of communication occur between the referring centres and the rehab services to discuss referral criteria, barriers and challenges to admission.</td>
<td>75%</td>
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<tr>
<td>5.3</td>
<td>Low</td>
<td>The team contacts referring centres, and responds within 48 hours to requests for rehabilitation services.</td>
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<tr>
<td>5.4</td>
<td>Low</td>
<td>The wait time from when a client has met criteria for being “rehab ready” by inpatient rehab services until admission to inpatient stroke rehabilitation is not more than 2 business days.</td>
<td>75%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Low</td>
<td>The team monitors its responsiveness by setting and tracking times for responding to requests for services and information.</td>
<td></td>
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</tr>
<tr>
<td>5.6</td>
<td>Low</td>
<td>The team regularly reviews the needs of stroke clients waiting for services and responds quickly to those who are in emergency or crisis situations.</td>
<td>Conditions considered as emergency situations include functional decline due to lack of access to other services in outpatient or community rehab setting, and family distress.</td>
<td>75%</td>
<td></td>
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</tr>
<tr>
<td>5.7</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team establishes partnerships or collaborations required to regularly monitor and reassess survivors of moderate or severe strokes who did not meet the criteria for inpatient rehab at the first assessment, and provides input on the client’s status and ongoing rehabilitation need</td>
<td>Not all clients with a moderate or severe stroke will eventually meet the criteria for inpatient rehab. Ensure there is a process to reassess clients remaining in acute care whose functional status improves over a longer duration and they become “rehab ready,” reaching the point they could benefit from inpatient rehabilitation. Process may include partnering or collaborating with those bodies that are able to identify and communicate with those clients that have not met the criteria for inpatient rehab at the first assessment.</td>
<td>red yellow green</td>
</tr>
<tr>
<td>5.8</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team has a process for stroke survivors to re-access rehab if clinically indicated, regardless of the time that has elapsed since the stroke.</td>
<td>Information about the process for re-accessing the stroke rehabilitation team or services should be clearly communicated to the client, family, referring centres, and community partners. Contact might be initiated in person, by telephone, written referral, or by e-mail, as appropriate.</td>
<td>red yellow green</td>
</tr>
<tr>
<td>6.0</td>
<td>Rehab team accurately and appropriately assesses clients to develop an individualized care plan for rehab.</td>
<td></td>
<td></td>
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<tr>
<td>6.1</td>
<td>Low</td>
<td>Target: 75%</td>
<td>From the time of first contact, the team informs the client and family of the interprofessional team member who has primary responsibility for coordinating the rehab services, and provides information on how to contact that person.</td>
<td>The assigned team member may be the most responsible physician or another member of the interprofessional team.</td>
<td>red yellow green</td>
</tr>
<tr>
<td>6.3</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team conducts functional assessments using standardized and valid assessment tools.</td>
<td>Assessment should include use of the Functional Independence Measure (FIM) as required by the Canadian Institute for Health Information (CIHI) National Rehabilitation Reporting System (NRS) for all rehabilitation clients.</td>
<td>red yellow green</td>
</tr>
<tr>
<td>6.4</td>
<td>High</td>
<td>Target: 90%</td>
<td>The team develops an individualized rehabilitation plan based on the client’s functional assessment that identifies required rehabilitation services, intensity and duration of therapy, and rehabilitation therapy goals.</td>
<td></td>
<td>red yellow green</td>
</tr>
<tr>
<td>6.5</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team includes discharge planning in each pt’s rehab plan by identifying transition issues specific to the client and family, caregiver training needs, safety and organizing home visits by health care professionals to assess the home environment.</td>
<td>Caregiver training includes how to assist the client to manage activities of daily living and instrumental activities of daily living in their environment. Visits to assess the home environment for suitability and safe discharge will determine equipment needs and any necessary home modifications.</td>
<td>red yellow green</td>
</tr>
<tr>
<td>6.6</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team conducts at least one formal interprofessional meeting per week to monitor clients’ progress in achieving their rehab goals.</td>
<td>The outcomes of the meetings as well as ongoing rehabilitation goals are discussed with clients and family.</td>
<td>red yellow green</td>
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<tr>
<td>6.7</td>
<td>Low</td>
<td>The team, clients, family, and caregivers regularly update the written rehabilitation plan on the progress made towards client goals, and anticipated discharge timing and destination.</td>
<td>The rehabilitation plan is a dynamic document that should be kept current, accurate, and communicate client information to team members in a timely way.</td>
<td>Red-Yellow-Green</td>
<td></td>
</tr>
<tr>
<td>6.8</td>
<td>Low</td>
<td>When client rehabilitation goals are not met, the team documents the reasons and updates the rehabilitation goals, discharge timing, and destination plans as appropriate.</td>
<td></td>
<td>Red-Yellow-Green</td>
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<tr>
<td>7.0</td>
<td></td>
<td>The stroke team provides comprehensive, safe, and timely inpatient stroke rehab</td>
<td></td>
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<tr>
<td>7.1</td>
<td>High</td>
<td>Clients admitted for inpatient stroke rehabilitation services are managed on a dedicated stroke unit.</td>
<td>A stroke unit is a geographically defined discrete area with beds designated for stroke clients receiving ongoing services from an interprofessional stroke team.</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>Low</td>
<td>When clients are not managed on a dedicated stroke unit, there is a process for clustering stroke clients.</td>
<td>Clustering stroke clients is a process whereby clients with stroke are identified and grouped, despite not being in a physically discrete stroke unit. ▪This process facilitates the use of stroke protocols and stroke services from specially trained service providers. ▪Clustered patients have access to healthcare professionals with stroke expertise and are followed by a stroke team.</td>
<td>Red-Yellow-Green</td>
<td></td>
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<tr>
<td>7.3</td>
<td>Low</td>
<td>When the team provides rehabilitative stroke care on general rehabilitation units or mixed units, protocols are used that are specific to the care and management of stroke clients.</td>
<td>Duration and intensity of therapy should be provided in accordance with the current Canadian Best Practice Recommendations for Stroke Care and be based on individual need and tolerance of clients. ▪The goal of therapy is to work up to the prescribed levels defined in the plan.</td>
<td>Red-Yellow-Green</td>
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<tr>
<td>7.4</td>
<td>Low</td>
<td>Team members deliver the appropriate intensity and duration of clinically relevant therapies across the care continuum as prescribed in the individualized rehabilitation plan.</td>
<td>Patient tolerance and stroke severity may impact the frequency and duration of therapy. Human resources to provide services may be another barrier to delivering the prescribed therapy.</td>
<td>Red-Yellow-Green</td>
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<tr>
<td>7.5</td>
<td>Low</td>
<td>The team delivers a minimum of one hour of direct therapy for each relevant core therapy, a minimum of five days per week, to each stroke rehabilitation client.</td>
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<td>Red-Yellow-Green</td>
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<tr>
<td>7.6</td>
<td>Low</td>
<td>The team promotes integrating the skills gained in therapy into the clients’ daily routine to increase their participation and activity.</td>
<td>The team includes family members, caregivers, and volunteers.</td>
<td>Red-Yellow-Green</td>
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<tr>
<td>7.7</td>
<td>Low</td>
<td>The team follows established protocols and mechanisms for the safety of stroke clients during inpatient rehabilitation.</td>
<td>Safety protocols include positioning and transferring, and therapy to affected limits, reduction of spasticity, communication protocols for clients with impaired speech, and environmental scans for clients with neglect. ▪Mechanisms for safety may include handrails, flooring, lighting, and physical layout of environment.</td>
<td>Red-Yellow-Green</td>
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## Bridgepoint Health – Stroke Distinction—Standards for Inpatient Stroke Rehabilitation

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<tr>
<td>7.8</td>
<td>Low</td>
<td>The team implements and evaluates a falls prevention strategy specific to stroke clients to minimize the risk of falls in this population.</td>
<td>The team develops and implements a falls prevention strategy that addresses the specific needs of stroke clients. The team should evaluate the falls prevention strategy to identify trends, causes, and degree of injury; and uses the information to make improvements to its falls prevention strategy.</td>
<td>Red</td>
<td>yellow</td>
</tr>
<tr>
<td>8.0</td>
<td></td>
<td><strong>The stroke rehab team prepares clients, families, and caregivers to address secondary stroke prevention.</strong></td>
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</tr>
<tr>
<td>8.1</td>
<td>Low</td>
<td>The team provides clients and their family/caregivers with information on lifestyle modifications to address cardiovascular risk factors for recurrent stroke during inpatient rehab.</td>
<td>Lifestyle and risk factor interventions should address a healthy balanced diet, reduced sodium intake, exercise, weight management, smoking cessation, and alcohol intake.</td>
<td>Yellow</td>
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</tr>
<tr>
<td>8.2</td>
<td>Low</td>
<td>The team assesses clients for the presence of hypertension and appropriately manages elevated blood pressure during inpatient rehab in all clients who have had a stroke.</td>
<td>Blood pressure is the single most important modifiable risk factor for stroke. Managing and reducing blood pressure is the responsibility of all health care professionals along the continuum of care for stroke clients. Blood pressure should be monitored throughout the hospital stay and managed according to current best practice, as defined in the Canadian Stroke Strategy’s Canadian Best Practice Recommendations for Stroke Care.</td>
<td>Yellow</td>
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<tr>
<td>8.3</td>
<td>Low</td>
<td>The team assesses clients for the presence of elevated lipid levels and appropriately manages elevated lipid levels in all clients who have had a stroke.</td>
<td>Secondary prevention strategies are the responsibility of all health care professionals dealing with stroke clients throughout rehabilitation and long-term recovery. Ischemic stroke clients with elevated lipids should be managed with dietary changes and pharmacotherapy as appropriate during inpatient rehabilitation.</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>8.4</td>
<td>High</td>
<td>The team prescribes all adult clients with ischaemic stroke or transient ischaemic attack with antiplatelet therapy for secondary prevention of recurrent stroke unless there are contraindications, or an indication for anticoagulation.</td>
<td>Aspirin (ASA), combined ASA and extended release dipyridamole, or clopidogrel, may be used depending on the clinical circumstances</td>
<td>Yellow</td>
<td></td>
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<tr>
<td>8.5</td>
<td>Low</td>
<td>The team assesses and manages diabetes in clients admitted to rehabilitation in accordance with the current Canadian Diabetes Association recommendations for the management of Diabetes.</td>
<td>Secondary prevention strategies are the responsibility of all health care professionals dealing with stroke clients throughout rehabilitation and long-term recovery. Diabetes in clients with stroke should be managed according to the current Canadian Diabetes Association recommendations for the management of Diabetes.</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>8.6</td>
<td>Low</td>
<td>The team treats adult clients with stroke and atrial fibrillation with anticoagulants unless contraindicated.</td>
<td>For clients on warfarin, international normalized ratios (INR) should be monitored regularly to achieve a target of 2.5 (range 2.0 – 3.0).</td>
<td>Yellow</td>
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<tr>
<td>8.7</td>
<td>Low</td>
<td>The team addresses compliance with the anticoagulation regimen with all stroke clients and their families/caregivers in their follow up with clients.</td>
<td>Education of clients, families and caregivers is an important component to compliance with anticoagulation. The rehab team incorporates secondary prevention into their educational programs and follows up with clients and families to maximize compliance following inpatient rehab. Patients prescribed anticoagulants should be provided with education that addresses the diagnosis of atrial fibrillation, risk of stroke with atrial fibrillation, importance of medication adherence, and compliance with INR monitoring, if required.</td>
<td>Yellow</td>
<td>Low (75%)</td>
</tr>
<tr>
<td>8.8</td>
<td>Low</td>
<td>The team follows mechanisms for referrals and follow-up for clients who are admitted to inpatient rehabilitation with carotid stenosis requiring possible surgical intervention.</td>
<td>Clients may be transferred to inpatient rehabilitation before referrals are made to appropriate surgical services. The rehabilitation team should have processes for contacting surgical services and ensuring clients have access to these services while in rehabilitation in a timely way. Carotid endarterectomy should be offered within 2 weeks for clients with 70 – 99% stenosis.</td>
<td>Yellow</td>
<td>Low (75%)</td>
</tr>
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**HELPING CLIENTS AND FAMILIES LIVE WITH STROKE**

9.0 The stroke rehabilitation team assesses and manages potential sequelae of stroke in an accurate and safe manner.

<p>| 9.1      | High     | The team screens and documents the client’s swallowing ability using a simple valid reliable testing protocol as part of their initial rehabilitation assessment. | Swallowing screening should be completed as part of initial rehabilitation assessment. Staff remains aware that clients should be monitored closely as swallowing abilities may decline. Using a validated screening tool will enhance early detection of dysphagia. Documentation of this process is important and should be added to pre-printed order and documentation records for acute stroke. | Green | High (90%) |
| 9.2      | Low      | The team refers clients with features indicating dysphagia or pulmonary aspiration for a full clinical assessment of their swallowing ability by a speech-language pathologist or appropriately trained specialist who should advise on swallowing ability and consistency of diet and fluids. | Referrals for full assessments of swallowing difficulties should be made as soon as possible after the initial assessment. Stroke clients require proper nutrition and delays in addressing swallowing difficulties could result in decreased nutritional status of clients. | Yellow | Low (75%) |
| 9.3      | Low      | The team refers clients who are at risk of malnutrition, including those with dysphagia, to a dietician for assessment and ongoing management. | Referrals should be done in a timely way to prevent further deterioration of nutritional status which will inhibit recovery. | Yellow | Low (75%) |
| 9.4      | Low      | The team determines whether the client has a history of depression, or risk factors for depression, at the time of the first rehabilitation assessment. | Clients with stroke are considered to be at a high level of risk for depression. Families and caregivers should also be provided information about the potential for depression, and provided information on accessing counselling services. | Yellow | Low (75%) |</p>
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<tr>
<td>9.5</td>
<td>Low</td>
<td>The team screens clients with stroke for depression at all transition points and whenever clinical presentation indicates.</td>
<td>Transition points include at admission to inpatient rehabilitation care, particularly if any evidence of depression or mood changes are noted; during early rehabilitation and while still in rehabilitation; prior to discharge home; and following discharge to the community.</td>
<td>yellow</td>
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<tr>
<td>9.6</td>
<td>Low</td>
<td>The team refers clients identified as at risk for depression during screening to a psychiatrist, psychologist, or social worker for further assessment, diagnosis, and development of a treatment plan.</td>
<td>Once the treatment plan has been developed it should be incorporated into the client's overall rehabilitation plan.</td>
<td>yellow</td>
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<tr>
<td>9.7</td>
<td>Low</td>
<td>The team screens all clients with vascular risk factors, clinically-evident stroke or transient ischemic attack, for cognitive impairment at all transition points using a validated screening tool.</td>
<td>Vascular risk factors include hypertension, age &gt; 65, hyperlipidemia, diabetes, clinical stroke, neuroimaging findings of covert stroke or white matter disease, damage to other target organs, and cognitive or functional changes that are clinically evident or reported during history taking. Transition points include during early rehabilitation and in-patient rehabilitation, prior to discharge home, and following discharge to the community.</td>
<td>yellow</td>
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<tr>
<td>9.8</td>
<td>Low</td>
<td>The team refers clients who demonstrate cognitive impairments in the screening process to a health care professional with specific expertise for additional cognitive, perceptual, and functional assessment to determine the severity of impairment and impact of deficits on function and safety in activities of daily living and instrumental activities of daily living, and to implement appropriate remedial, compensatory, and adaptive intervention strategies.</td>
<td>Once the treatment plan has been developed it should be incorporated into the client's overall rehabilitation plan.</td>
<td>yellow</td>
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**10.0 The stroke rehabilitation team effectively reintegrates clients and families into the community after inpatient stroke rehabilitation.**

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<tbody>
<tr>
<td>10.1</td>
<td>Low</td>
<td>The team works with clients, families and caregivers to develop a transition and follow-up plan that includes referrals for additional or follow-up services, and an individually prescribed exercise program.</td>
<td>The team remains responsible for the client until in-patient services have been ended or the client is transferred to another stroke rehabilitation team or organization, such as long term care.</td>
<td>yellow</td>
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</tr>
<tr>
<td>10.2</td>
<td>Low</td>
<td>The team provides stroke clients, families and caregivers with information regarding ongoing recovery, signs or symptoms of declining health status, and contact information for follow-up with the team.</td>
<td>Continuity of care is enhanced when clients and their families have comprehensive information about ongoing health, transitions, and end of service. This will aid in reducing the stress of transition to home/community, and also help to minimize delays in discharge when the client is determined to have met their inpatient rehabilitation goals.</td>
<td>yellow</td>
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<tr>
<td>10.3</td>
<td>Low</td>
<td>The team provides clients, families, and caregivers with education and support to identify and adjust to changes in roles and lifestyle.</td>
<td>Transitions from inpatient rehabilitation and reintegration into the community is enhanced when clients and their families have comprehensive information about the changes that may be required in their environment, work-life, financial issues, and expected progress for further recovery.</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>Low</td>
<td>The team provides education that promotes self-efficacy through mastering self-management skills.</td>
<td>Education that promotes self-efficacy may include: • action planning; • modeling behaviors and problem solving strategies; • reinterpreting symptoms; and social persuasion through group support and guidance for individual efforts. • Self-management training topics should include: • exercise; • nutrition; • symptom management techniques; • risk factor management; • fatigue and sleep management; • use of medications; • managing emotions of fear, anger and depression; • cognitive and memory changes; • training in communication with health professionals and other individuals; and • health-related problem solving and decision making.</td>
<td>Yellow</td>
<td></td>
</tr>
<tr>
<td>10.5</td>
<td>Low</td>
<td>The team provides training to family and caregivers to safely care for clients after discharge.</td>
<td>In order to safely care for clients after discharge, family and caregiver education should include training on: • personal care techniques; • communication strategies; • physical handling techniques; • other daily living activity goals and preferences; • how to access community services and resources; • problem-solving techniques; • health system navigation; and self-management.</td>
<td>Green</td>
<td></td>
</tr>
<tr>
<td>10.6</td>
<td>Low</td>
<td>The team provides clients, families, and caregivers with a list of primary care physicians, community-based rehabilitation, home care services, psychological counseling, caregiver training, stroke client support groups, and vocational counseling services in the community.</td>
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October 17, 2012 Updated Nov 21, Updated Dec 10,
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<tr>
<td>10.7</td>
<td>Low</td>
<td>75%</td>
<td>The team works with clients, families, and caregivers to help them access primary care, home and community services, community-based rehabilitation, and psychological counseling services.</td>
<td>Stroke often leaves clients with ongoing functional impairments and as a result, families and caregivers are often expected to take on care responsibilities that require knowledge and skills that may be beyond their scope. Increases in caregiver burden may result in depression among caregivers of stroke clients (rates as high as 60 percent has been reported). It is important that stroke clients, families and caregivers know how to access support services when they need them.</td>
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</tr>
<tr>
<td>10.8</td>
<td>Low</td>
<td>75%</td>
<td>The team coordinates referral for follow-up secondary prevention services required by clients before leaving inpatient stroke rehabilitation.</td>
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<tr>
<td>10.9</td>
<td>Low</td>
<td>75%</td>
<td>Following transition or end of service, the team contacts clients and families to evaluate the effectiveness of the transition, and uses the information to improve its transition and end-of-service planning.</td>
<td>The team contacts clients, families and caregivers, or referral organizations, to monitor the results of the transition or end of service for clients, and the progress on follow-up plans. The team verifies that the stroke survivor’s needs have been met with transition placement, and works to ensure any outstanding needs are addressed as appropriate.</td>
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**MAINTAINING ACCESSIBLE AND EFFICIENT CLINICAL INFORMATION SYSTEMS**

11.0 The team establishes and uses a stroke clinical information system to monitor client care and management, and plan inpatient stroke rehabilitation services.
## Bridgepoint Health – Stroke Distinction—Standards for Inpatient Stroke Rehabilitation

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<tr>
<td>11.1</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team maintains a clinical information system that collects information for each client, including stroke symptoms, treatments and interventions.</td>
<td>The clinical information system can be paper-based or electronic. Information can be gathered in real time, or retroactively through chart audits. This information system may be dedicated to stroke (such as a clinical database or registry) or part of a broader organizational information system that contains specific information regarding stroke clients that can be accessed and used for stroke management.</td>
<td></td>
</tr>
<tr>
<td>11.2</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team gathers and organizes information in the clinical information system across the continuum of stroke services.</td>
<td>The continuum of stroke services includes prevention, EMS, ED, acute inpatient, rehabilitation, follow-up clinics, primary care, and community-based services.</td>
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<tr>
<td>11.3</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The clinical information system is linked to decision support tools such as evidence-based guidelines and screening tools for stroke.</td>
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<tr>
<td>11.4</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team uses the system to obtain information about client risk factors, appropriate stroke management and intervention, and to schedule appointments for clients and families.</td>
<td></td>
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<tr>
<td>11.5</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team uses information from the clinical information system to create reports about stroke system performance and use of decision support tools.</td>
<td></td>
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<tr>
<td>11.6</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team shares reports about stroke system performance and use of decision support tools within the rehabilitation site, and with clients and families, primary care providers, and community-based services.</td>
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<tr>
<td>11.7</td>
<td>Low</td>
<td>Target: 75%</td>
<td>The team has security, back-up, and confidentiality systems in place for the stroke data to meet legislation for protecting privacy and integrity of information.</td>
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### MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

12.0 The team uses data to monitor quality and achieve positive outcomes for inpatient stroke rehabilitation services.

October 17, 2012 Updated Nov 21, Updated Dec 10,
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<tbody>
<tr>
<td>12.1</td>
<td>Low</td>
<td>The inpatient stroke rehabilitation team accesses and reviews clinical and service utilization data.</td>
<td>This data is available from the organization’s central information system and should be accessed and reviewed by members of the team on a regular basis, e.g., monthly, quarterly.</td>
<td>75%</td>
<td>Red (Low)</td>
</tr>
<tr>
<td>12.2</td>
<td>High</td>
<td>The team identifies and monitors standardized process and outcome performance measures for inpatient stroke rehabilitation.</td>
<td>Standardized measures have been developed nationally as part of the Canadian Stroke Strategy’s Canadian Best Practice Recommendations for Stroke Care. Stroke teams monitor the core performance measures required by Accreditation Canada for effectiveness of services; linkages, including timeliness of transitions; and best practice recommendations they have implemented. Additional standardized performance measures are also available for more detailed monitoring.</td>
<td>90%</td>
<td>Green (High)</td>
</tr>
<tr>
<td>12.3</td>
<td>Low</td>
<td>The team monitors client and family perspectives on the quality of inpatient stroke services.</td>
<td>The team seeks stroke rehabilitation clients’ perspectives through surveys, interviews, focus groups, or meetings. Families and caregivers are included in the feedback process.</td>
<td>75%</td>
<td>Yellow (Low)</td>
</tr>
<tr>
<td>12.4</td>
<td>Low</td>
<td>The team compares its results on performance measures with other similar interventions, programs or organizations.</td>
<td>The team may participate in benchmarking opportunities for stroke rehabilitation by collaborating with national initiatives and working with peer organizations to assess its performance and identify opportunities for improvement. The team also identifies and shares leading practices.</td>
<td>75%</td>
<td>Yellow (Low)</td>
</tr>
<tr>
<td>12.5</td>
<td>High</td>
<td>The team uses information it collects about the quality of services to identify successes and opportunities for improvement, and make improvements in a timely way.</td>
<td>Ongoing quality improvement initiatives in stroke rehab focus on improving the quality of services, implementing best practices and monitoring their impact, and efficient use of available resources to maximize access and services for stroke rehab.</td>
<td>90%</td>
<td>Green (High)</td>
</tr>
<tr>
<td>12.6</td>
<td>Low</td>
<td>The team shares evaluation results with staff, clients, and families.</td>
<td>Sharing the results of evaluations and improvements helps staff to become familiar with the philosophy and benefits of quality improvement. It also increases the family and client’s awareness of the stroke program’s commitment to quality of care and ongoing quality improvement.</td>
<td>75%</td>
<td>Yellow (Low)</td>
</tr>
</tbody>
</table>
Venous Thromboembolism (VTE) Assessment

1. This patient is at high risk for VTE (Padua¹ score 4 or more), or has another indication, and has been prescribed (check all that apply):
   - Low Molecular Weight Heparin
   - Warfarin
   - Fondaparinux
   - TED stockings
   - Other_______

2. If no VTE prophylaxis has been prescribed, please indicate reason (check all that apply):
   - Low VTE risk (Padua Score¹ less than 4)
   - High bleeding risk (e.g. IMPROVE² score 7 or more)
   - VTE therapy completed
   - Contraindication to TEDs
   - Other_________________________________

3. This patient may require post discharge VTE prophylaxis.

CLINICAL DECISION SUPPORT TOOLS:

<table>
<thead>
<tr>
<th>¹Thrombosis risk – Padua Prediction Score</th>
<th>²Bleeding risk – IMPROVE risk score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Active Cancer (local or distant metastases or chemo or radiation in last 6 months)</td>
<td>1 Male</td>
</tr>
<tr>
<td>3 Previous VTE (not including superficial vein thrombosis)</td>
<td>1.5 Age 40-84</td>
</tr>
<tr>
<td>3 Reduced Mobility (in bed for 3 or more days)</td>
<td>3.5 Age 85 or older</td>
</tr>
<tr>
<td>3 Thrombophilic condition (defects of antithrombin, Protein C or S, Factor V Leidin)</td>
<td>2.5 Recent ICU/CCU stay (less than 30 days ago)</td>
</tr>
<tr>
<td>2 Recent trauma and/or surgery (1 month or less)</td>
<td>2 Central Venous Catheter (exclude PICC line)</td>
</tr>
<tr>
<td>1 Age 70 or older</td>
<td>2 Current cancer</td>
</tr>
<tr>
<td>1 Heart and/or respiratory failure</td>
<td>2 Rheumatic disease</td>
</tr>
<tr>
<td>1 Acute myocardial infarction or ischemic stroke</td>
<td>4 Major bleed in the 3 months prior to admission</td>
</tr>
<tr>
<td>1 Acute infection and/or rheumatologic disorder</td>
<td>4.5 Active gastroduodenal ulcer</td>
</tr>
<tr>
<td>1 Obesity (BMI 30 or greater)</td>
<td>1 Moderate renal failure: Creatinine Clearance 30–60 mL/min/m²</td>
</tr>
<tr>
<td>1 Ongoing hormonal treatment</td>
<td>2.5 Severe renal failure: Creatinine Clearance less than 30 mL/min/m²</td>
</tr>
</tbody>
</table>

Total VTE Risk Score

Total Bleeding Risk Score

Physician NAME SIGNATURE DATE (YYYY-MM-DD) TIME

Form No. (Assigned by Health Records Committee) Dev. (Feb 2013)*** Send Yellow copy to Pharmacy upon completion

Page 1 of 1
What can I do to prevent a blood clot while I am in hospital?

• Start physical activity and walking as soon as your doctor allows it. If you are unable to walk, try to move your legs and feet by making circles with your ankles as often as you can.
• Ask your doctor or nurse, “What is being done to reduce my risk of getting a blood clot?”
• Talk to your doctor about risk factors (see inside panel).
• Tell your doctor or nurse right away if you develop any signs or symptoms of a blood clot (see inside panel).
• Tell your health care team about any medications you are taking, including vitamins and other supplements, no matter how unimportant you think these are.

Your healthcare team members are here to answer any questions you may have.

Reference: National Health System. Patient.co.uk; VTE, 2012

What will be done to reduce my risk of a blood clot while I’m in hospital?

• Your risk of developing a blood clot will be assessed by your doctor and team when you are admitted to hospital and repeated during your stay.
• Your doctor may prescribe a medication to reduce your risk of developing a blood clot. The medication may be a pill you swallow each day or you may have a small injection in your abdomen daily. It is sometimes necessary to continue taking this treatment at home.
• You may be fitted with special stockings designed to squeeze your leg muscles to keep your blood circulating and reduce blood clots.
• The team will get you up and out of bed as soon as possible. Your therapist will develop a treatment plan to get you moving.
What is a DVT?

Veins are blood vessels that take blood towards the heart. Sometimes a clot will form in the deep veins of the leg. This is called a ‘deep vein thrombosis’ or DVT. A DVT blocks the normal flow of blood through the vein and causes leg pain, redness, tenderness and swelling.

Is a DVT serious?

A DVT by itself usually is not life threatening; however, sometimes part of the blood clot can break off and move through the bloodstream. The clot will keep travelling until it gets stuck in a narrow vein, often in the lung.

What is a PE?

A blood clot in the lung is called a ‘pulmonary embolism’ or PE. A PE can cause chest pain and problems breathing. This is extremely serious and if not treated quickly can lead to death.

What are the signs and symptoms of DVT and PE?

**Signs and symptoms of a DVT:**
- Pain or tenderness in the lower part of the leg
- Swelling of the leg
- Red or discoloured skin on the leg
- The leg is warm to touch

**Signs and symptoms of a PE:**
- Pain in your chest, back or ribs which can get worse when you take a deep breath
- New shortness of breath
- Unexplained coughing
- Coughing up blood

How are DVT and PE treated?

DVT and PE can be prevented and treated. There are medicines called anticoagulants (often called blood thinners) that prevent the existing clot from getting bigger and stops new clots from forming.

Why would I get a DVT or PE?

Anyone can get a DVT or PE. Some people are more at risk than others.

The chance of developing a blood clot will increase if:
- You are bedridden or have very limited ability to walk
- You smoke
- You have had a major operation within the last 3 months
- You have broken your leg, pelvis or hip recently
- You or a close family member have had a blood clot before
- You have cancer or are receiving cancer treatments
- You have heart or lung disease
- You are very overweight
- You are over 60 years of age
- You have an infection or a medical illness
- You have inflammatory bowel disease
- You have varicose veins that are inflamed (phlebitis)
- You have a condition that makes your blood more likely to clot
- You are pregnant or have recently given birth
- You are taking a birth control pill or hormone replacement therapy

Talk to your health team if you think you may be at risk. We are here to help you.

If you experience any signs or symptoms of a DVT or PE tell your doctor or nurse immediately.
Stroke Distinction Protocol: Swallowing Ability Assessment

The team screens and documents the client’s swallowing ability using a simple, valid and reliable testing protocol as part of their initial rehabilitation assessment.

All interprofessional team members are alerted in advance to new admissions via an email from the Admitting & Utilization department. When the team receives the referral the patient is assigned to one of five interprofessional care modules based the current caseloads of each module. Within the modules, individual disciplines review the anticipated admission and assign accountability for the patients care. In the case of an initial swallowing screen, the new admission will be assigned to one of three inpatient stroke program speech language pathologists (SLPs) depending on their module allocation.

Within the stroke rehabilitation program all patients will receive a referral for SLP. The SLP will initiate a swallowing safety screen on the day of admission. A swallowing screen includes the following elements:

1. A comprehensive review of the patient’s health record with emphasis on transfer documentation pertaining to diet type and diet texture. SLPs research the record for details related to swallowing issues and find documentation from the transferring SLPs and dietitians. In circumstances where there appears to be insufficient supporting documentation, clinicians will often attempt to contact the transferring site to seek additional detail.
2. A face-to-face interview with the patient and/or family/SDM to assess for any history of swallowing issues.
3. A consultation with interprofessional colleagues (i.e. most responsible nurse, registered dietitian) to identify if any swallowing issues have been reported or observed during admission assessments.
4. Oral/motor exam is completed if patient can be assessed through direct observation by the SLP at mealtime or snack time.
5. Diet texture order will be revised as required by the SLP based on the findings of the swallowing screen. Under the Bridgepoint Active Healthcare Medical Directive: SLP Generation and Revision of Diet Texture Orders, the SLP write and transcribe a diet texture order, via the non-medication order entry system in the electronic health record.

Any revisions to diet texture orders will be communicated to the interprofessional team through written documentation in the electronic health record and through verbal communication with the most responsible nurse at the time of revision. For high risk patients, signage may also be placed at the patient’s bedside indicating the patient’s diet texture status.

If any revisions are made to the diet texture (upgrades or downgrades) based on the screen, the SLP will reassess the patient within 24 hours.
SLP Dysphagia Screening Process at Admission

Preadmission email received from Admitting indicating Stroke diagnosis

Patient preadmitted to 1 of 5 interprofessional modules (for shared SLP modules, patient is assigned based on SLP caseload). Email usually received one day prior to admission

Patient Admitted to 3N/3S

Stroke/Neuro Order set completed by MRP. SLP receives a referral for all new admissions via NMOE.

All stroke patients seen by SLP on day of admission for screening and/or comprehensive initial assessment.

Screen or Comprehensive Assessment

Decision based on priority matrix considering patient safety and caseload demands

SCREENING: 1) Comprehensive Chart review 2) Patient/SDM Interview 3) Consult with Interprofessional Team 4) Oral/motor exam completed IF patient can be assessed at mealtime 5) Revise diet texture as appropriate.

INITIAL ASSESSMENT: Comprehensive assessment of rehabilitation needs including admission dysphagia screen

Document Initial Admission Assessment in Focus Note: Admission

No change to Admission Diet: Reassess at one week

Downgrade from Admission Diet: Reassess next day

Upgrade from Admission Diet: Reassess next day

Document Dysphagia Screen in Focus Note: Speech/ Swallowing
Stroke Services Distinction
Accreditation Canada
Objectives for Today

1. Provide an overview of the requirements for Stroke Distinction
2. Describe the work that has been completed to date to support successful achievement of the requirements
3. Identify remaining opportunities for improvements
4. Develop an understanding of your role in the Stroke Distinction process
5. Establish Next Steps
Overview of Stroke Distinction:

1. Recognizes healthcare organizations that demonstrate clinical excellence and an outstanding commitment to leadership in stroke care.
2. Stroke Distinction standards are based on Canadian Best Practice Recommendations for Stroke Care.
4. Stroke Distinction Award is a 2-year process independent of the Qmentum Accreditation Process.
5. Bridgepoint was successfully awarded a grant from the Ontario Stroke Network to support our pursuit of Stroke Distinction.
6. Bridgepoint applied and was accepted into Accreditation Canada’s Stroke Distinction Award Program in Sept 2012.
Benefits of Distinction Award:

1. Formal recognition of stroke expertise
2. Opportunity to showcase excellent programs and services at Bridgepoint (Inpatient & Outpatient)
3. Less than 10 organizations across Canada have stroke distinction - TRI only other Rehab site
4. Enables stroke specific staffing patterns and resource allocation
5. Demonstrates Bridgepoint’s commitment to excellence in stroke care
Requirements:

1. Provide evidence through documentation and performance that the 5 core requirements of Stroke Distinction are completed, implemented and achieved
2. On site evaluation by 2 surveyors (stroke experts) planned for Sept 16 and 17, 2013
3. Uses survey methodology similar to Qmentum - while on site surveyors will be talking to staff, physician, patients, clinical leaders, reviewing documentation and other materials
4. Data submission (evidence binder) by Aug 2, 2013
5. Indicator data to be submitted every 6 months post visit to keep distinction
6. Focus is on 20 Inpatient Rehab beds and Ambulatory Care
7. Mock tracers will be conducted at the end of August.
Planning Requirements

 Achievement of performance indicator thresholds

 Commitment to patient and family education

 Achievement of standards of excellence

 Commitment to excellence and innovation

 Implementation of stroke protocols or clinical practice guidelines
<table>
<thead>
<tr>
<th>Achievement of Standards of excellence</th>
<th>Implementation of stroke protocols or clinical practice guidelines</th>
<th>Commitment to client and family education</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 76 standards divided into 5 key areas</td>
<td>• 3 protocols for inpatient rehab</td>
<td>• Relevant to the changing needs of patient and family</td>
</tr>
<tr>
<td>• Key areas include:</td>
<td>• Swallowing ability assessment</td>
<td>• Education materials are available in a variety of languages appropriate to the client</td>
</tr>
<tr>
<td>• 12 standards considered high priority, must meet 90%</td>
<td>• Initial assessment of rehab needs</td>
<td>• Feedback from patients and families that they received education</td>
</tr>
<tr>
<td>• Initial review resulted in 15 yellows and 4 reds</td>
<td>• Assessing and managing diabetes mellitus when present</td>
<td>• Standardized tool used to document components of educational provided</td>
</tr>
</tbody>
</table>

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Commitment to excellence and innovation

- Submit 2 fully implemented projects or initiatives that follow stroke best practice guidelines and integrate latest research and evidence
- Criteria:
  - Evidenced based
  - Adds to the overall quality of stroke services
  - Includes comprehensive evaluation, measures sustainability of project
  - Communicates findings within the organization and externally
  - Notable for what it could contribute to the delivery of stroke services
- 2 projects chosen are: Choices and Change and Smoking Cessation

Achievement of performance indicators thresholds

- 4 core indicators:
  - Proportion of stroke clients treated on a dedicated stroke unit (80% +)
  - LOS in an inpatient rehab unit (median of 14 + days)
  - Proportion of ischemic stroke and TIA prescribed antithrombotic therapy (90% +)
  - Proportion of clients with initial dysphasia screening at additions (90% +)
- 2 optional indicators: % of patients with stroke that experience complications and change in functional status using a standardized measurement tool (time of admission and time of discharge) (90% of patients to improve by 20 points)
Achieving the Requirements

Work Completed to Date
Achieving the Standards

1. Confirmation of top priority standards (12) – require 90% compliance (*see attached document for reference*)
2. Self-Assessment of compliance with all 76 standards completed
3. Each standard rated for compliance using a coding system: green (standard successfully met), yellow (standard partially met), red (standard not met)
4. Initial review resulted in 15 yellows and 4 reds
5. Plan implemented to begin to address gaps
## Inpatient Standard Review: Gaps

<table>
<thead>
<tr>
<th>Gaps identified</th>
<th>Plan to address:</th>
</tr>
</thead>
</table>
| 2.6 The team uses information from staff performance evaluations to improve stroke rehab services and identify support, training or development needs for the team. | • Feedback provided informally  
• Plan in place to begin performance reviews |
| 6.7 The team, clients, family and caregivers regularly update the written rehab plan on the progress made towards client goals, and anticipated discharge timing and destination. | • Treatment plans and goals are developed based on initial assessments and discussed with patients/families  
• Patients and families are part of discharge planning and are informed of discharge dates  
• Discharge dates are based on best practice and ALOS information  
• During rounds, patient progress is discussed and documented. Each discipline also provides progress updates in their notes. |
| 9.4 The team determines whether the client has a history of depression or risk factors for depression at the time of the first rehab assessment. | • MD and SW do assess patients but there is no formal assessment tool in place. |
| 9.5 The team screens clients with stroke for depression at all transition points and whenever clinical presentation indicates. |
Achieving the Standards *(cont..)*

1. Depression screening process mapped with inpatient social work and discussion regarding the possibility to pilot a formal depression screen

2. Venothromboembolism (VTE) protocol with order sets developed and in the process of implementation
Stroke Protocols

1. The team screens and documents the client’s swallowing ability using a simple valid reliable testing protocol as part of the initial assessment of rehabilitation needs
   - Swallowing screening process algorithm for all new admissions completed and screening process defined (? validated tool?)

2. The team assesses the client’s stroke-related impairments and functional status within 24-48 hours of admission
   - Assessment of rehab needs reviewed in chart audit
   - Team has a process to assign and assess new admits
Stroke Protocols

1. The team assesses and manages diabetes in clients admitted to rehabilitation in accordance with the current CDA recommendations
   - Advanced practice nurse has reviewed the Canadian diabetes best practice guidelines and algorithms and inservices are being planned for inpatient and outpatient staff.
   - The physicians developed an algorithm to reflect current practice that aligns with best practices
Patient & Family Education

Evaluation

1. Evidence that client education is an integrated component of stroke care delivery: (4/4)

- Client education materials available and accessible on the ward
- Client educational materials available in a variety of languages
- Client educational materials available in formats appropriate for persons with special communication needs
- In interviews with client & families, clients report receiving education regarding their stroke, recovery, and self-management
2. Consistent documentation in the client medical record that client and family education has been provided: (2/4)

- Standardized tool (e.g. checklist used to document components of education provided to ensure all critical elements addressed)
- Consistent location in client chart for documentation of client education
- Documentation of education provided by each healthcare profession within the discipline notes notes
- Documentation of specific content addressed during an educational session
Patient & Family Education

Actions

1. Client & Family education working group established
2. Client & Family education standards reviewed with teams
3. Patient education documentation tool being piloted on 3N/3S
4. Standardized patient education packages in development
5. Working with Patient Library to ensure a comprehensive set of materials are available for patients
6. Brochure stands being made available on Ground & 3rd to provide access to patient materials

HELP

What tools do you want included in the education packages and made available on the units? Examples of Special tools required!
Excellence & Innovation

Identification of Excellence & Innovation Projects for Submission

1. Smoking Cessation – Phase 1 – OMSC
   Smoking Cessation – Phase 2 – Smoking Demonstration Project (Choices & Changes)

2. Transitions in Care – Inpatient to Outpatient
Performance Indicators

- Reviewed 76 charts
- Indicator data collected for 4 core and 2 optional indicators
- Chart audit completed to review documentation to support indicator reports and protocol implementation
Your Role as Stroke Experts

• Familiarize yourself with stroke best practice recommendations
• Be knowledgeable about Stroke Distinction Requirements
• Validate the self-assessment gaps and work together to develop a plan to address
• Refresh the stroke client and family education tools including the “Stroke Patient Guide”
• Provide suggestions and feedback into care processes, practices and materials required to successfully meet standards

Any and ALL feedback welcome!
Your Role as Stroke Experts

• Review & revise pilot process to document evidence of patient education
• Support creation and collection of materials for the Evidence Binder
• Attend Lunch & Learn Sessions July 11, July 19 & August 8
• Identify ways in which we can support your success in achieving Stroke Distinction
• Be willing to participate in the development and implementation of strategies to achieve best practices
• Implement new best practice suggestions for newly admitted patients beginning in early August

• Be able to articulate the excellent care you provide!
Next Steps:

Communication:
- What method of 2 way communication would work for the team?
  - Stroke Distinction board/section?
  - Standing meeting agenda item (how often?)
  - Dedicated meetings?
  - Attend lunch and learn sessions

Engagement:
- Are there other ways to engage and involve the team?
  - Themed weeks? 10 weeks to go!
  - Stroke Tips?
  - Small working group?

Requirements:
- Does the team require anything right now?
  - Questions? Thoughts? Ideas?
  - Anything missing?
Stroke Education Series
For patients and families

What is it?
Weekly educational and peer support sessions on stroke, for patients and friends/family.

Who is it for?
Any patient (inpatient or day treatment patient) at Bridgepoint Active Healthcare who has suffered a stroke. Families and friends are also highly encouraged to attend to help support you in your recovery.

When is it?
Sessions run every week on Thursdays from 3:30 – 4:30 p.m. (occasionally 3 – 4 p.m.). Sessions are approximately one hour in length.

Where is it?
Dining room located on the 3rd floor of the hospital.

What will I learn about?
Topics will include:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction to stroke – what is stroke, risk factors and prevention</td>
<td>Thurs Sept 5, 2013</td>
</tr>
<tr>
<td>2. Recovery after a Stroke – what to expect and how to maximize recovery</td>
<td>Thurs Sept 12, 2013</td>
</tr>
<tr>
<td>3. Communication, swallowing and diet after a stroke</td>
<td>Thurs Sept 19, 2013</td>
</tr>
<tr>
<td>4. Psychological well-being after a stroke</td>
<td>Thurs Sept 26, 2013</td>
</tr>
<tr>
<td>5. Getting back into life after a stroke – adaptive aids and resuming previous activities</td>
<td>Thurs Oct 3, 2013</td>
</tr>
<tr>
<td>6. Transitioning home and into the community</td>
<td>Thurs Oct 10, 2013</td>
</tr>
</tbody>
</table>
Bridgepoint Stroke Education Series, Session 1-
Introduction to Stroke
Bridgepoint Stroke Education Series

✓ Weekly sessions- Thursdays from 330-430 (dining room)
✓ For inpatient and outpatient stroke survivors and their friends and family
✓ Combination of information and peer support
✓ Not meant to cover EVERYTHING, but to answer questions relevant to YOU, and guide you to further resources (websites, staff, etc)
Bridgepoint Stroke Education Series

6 rotating topics
• Week 1 – introduction to stroke
• Week 2 – neurorecovery
• Week 3 – speech/communication and swallowing
• Week 4 – psychosocial wellbeing and financial support
• Week 5 – resources and supports for functioning at home and in the community
• Week 6 – transition home and community resources
Introductions

• Name/ any friends and family here
• What has been your experience of living with a stroke so far?
• What you hope most to get out of these sessions?
Outline of Session

What is a stroke
Signs/symptoms of a stroke
Risk factors for a stroke
Prevention of a stroke
Medications
What is a Stroke?

• AKA- "cerebral vascular accident" or CVA
• Injury to a part of the brain
• Every stroke is different
• Severity and presentation will depend on size and location of the stroke
Types of Stroke
Hemorrhagic versus Ischemic

artery bursts in the brain

blood clot blocks blood flow to the brain
Transient Ischemic Attack (TIA)

• AKA “mini stroke”, ischemia but not infarction
• Temporary blockage in blood vessel in the brain- symptoms last <24 hrs
• serious warning sign, seek medical attention ASAP. risk of subsequent stroke:
  – 11% over the next 7 days
  – 24-29% over the following 5 years
Main Warning Signs

call 911! TIME IS BRAIN...

Stroke Warning Signs:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body.
- Sudden trouble walking, dizziness, loss of balance or coordination.
- Sudden severe headache with no known cause.
- Sudden trouble seeing in one or both eyes.
- Sudden confusion, trouble speaking or understanding.
Warning Signs: FAST

SPOT A STROKE

FACE DROOPING
ARM WEAKNESS
SPEECH DIFFICULTY
TIME TO CALL 911

Stroke Warning Signs and Symptoms
Risk Factors

Non-modifiable

• Gender,
• Race
• Age &
• Family History
**Stroke Risk Scorecard**

Each box that applies to you equals 1 point. Total your score at the bottom of each column and compare with the stroke risk levels on the back.

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>HIGH RISK</th>
<th>CAUTION</th>
<th>LOW RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>□ ≥140/90 or unknown</td>
<td>□ 120-139/80-89</td>
<td>□ &lt;120/80</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>□ Irregular heartbeat</td>
<td>□ I don’t know</td>
<td>□ Regular heartbeat</td>
</tr>
<tr>
<td>Smoking</td>
<td>□ Smoker</td>
<td>□ Trying to quit</td>
<td>□ Nonsmoker</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>□ ≥240 or unknown</td>
<td>□ 200-239</td>
<td>□ &lt;200</td>
</tr>
<tr>
<td>Diabetes</td>
<td>□ Yes</td>
<td>□ Borderline</td>
<td>□ No</td>
</tr>
<tr>
<td>Exercise</td>
<td>□ Couch potato</td>
<td>□ Some exercise</td>
<td>□ Regular exercise</td>
</tr>
<tr>
<td>Diet</td>
<td>□ Overweight</td>
<td>□ Slightly overweight</td>
<td>□ Healthy weight</td>
</tr>
<tr>
<td>Stroke in Family</td>
<td>□ Yes</td>
<td>□ Not sure</td>
<td>□ No</td>
</tr>
<tr>
<td>TOTAL SCORE</td>
<td>□ High Risk</td>
<td>□ Caution</td>
<td>□ Low Risk</td>
</tr>
</tbody>
</table>

**Risk Scorecard Results**

- **High Risk ≥3**: Ask about stroke prevention right away.
- **Caution 4-6**: A good start. Work on reducing risk.
- **Low Risk 6-8**: You’re doing very well at controlling stroke risk!
STROKE RISK FACTORS

ESTIMATED INCREASE IN RISK

ATRIAL FIBRILLATION  17 times
HYPERTENSION 2 TO 4
CARDIAC DISEASE 2 TO 4
NO EXERCISE 1.8 TO 3.5
DIABETES 1.5 TO 2.5
SMOKING 1.5 TO 2.5
HEAVY ALCOHOL USE 1 TO 3
Consider...

- Diet
- Exercise
- Stress
- Lifestyle
- Smoking/alcohol
- Regular checkups
Medications

If ischemic stroke:

• blood thinner such as aspirin, clopidigrel (TM Plavix), or ASA-dipyridamole (TM Aggrenox).
• warfarin (TM coumadin) or dabigatran (TM Pradax) if you have atrial fibrillation

You may also be on:

• cholesterol medication,
• blood pressure medication
• diabetes medication

Talk to your team re: smoking cessation
Atrial Fibrillation

- Abnormal beat of the heart (atrium)
- Causes clots to form in heart which can shower up to brain
- Increases risk by 5-17X! (3-4% risk/yr, but up to 5-10%/yr if prior stroke/TIA)
- Risk increases with increased age, hypertension and diabetes
- Anticoagulation extremely important
Blood Pressure

Normal Number 120/80

120 is called the SYSTOLIC
★ This is the pressure on the blood vessel when the heart pumps the blood to the body

80 is called the DIASTOLIC
★ This is the pressure on the blood vessel when the heart is at rest
High Blood Pressure

Blood pressure after a stroke should ideally be less than 130/80
• Consider home monitor device
• Keep log of different times of day
• Diet (low salt, healthy heart)- (up to 14) and exercise- (4-6) are very important
• See Mayo clinic handouts
• Can increase stroke risk by 4-6 X
Blood Pressure Medication

5 types:

• **Diuretics**: hydrochlorothiazide (HydroDiuril®), furosemide (Lasix®), spironolactone (Aldactone®).

• **ACE inhibitors**: lisinopril (Zestril®), perindopril (Coversyl®), ramipril (Altace®)

• **Angiotensin II Receptor Blockers (AKA ARBs)**: candesartan (Atacand®), losartan (Cozaar®), valsartan (Diovan®)

• **Calcium Channel Blockers**: amlodipine (Norvasc®), diltiazem (Cardizem®), felodipine (Renedil®)

• **Beta Blockers**: atenolol (Tenormin®), metoprolol (Betaloc®), bisoprolol (Monocor®)
Cholesterol

• your total cholesterol should be <4, and your “bad cholesterol” (LDL) should be <2

• Cholesterol medications (statins-rosuvastatin, atorvastatin) may be helpful in preventing stroke and heart attack even when cholesterol levels are normal
Diabetes

• Increases risk by 4X
• Diet, exercise, medications and monitoring of blood pressure/ HgA1C (coated candy apple)
• your blood sugar should be between 4-8 ideally (OK to be slightly higher in hospital while body under stress)
Smoking and Alcohol

• Smoking increases risk by 2X, but also increases risk for high blood pressure, heart attack, lung cancer, etc
• Smoking cessation is one of the most important things to do to prevent another stroke
• Talk to our cessation counsellor about options (medications, patches, inhalers, support, etc)
Alcohol

- SMALL amounts of alcohol may be protective...however
- Excessive alcohol (>1/day or 2/day if male and under age 65) increases risk of stroke (embolic and hemorrhagic)
- Also, alcohol consumption after stroke slows the healing process of the brain and may impair recovery- therefore it is recommended to abstain from alcohol after stroke
Other: stress and sleep

• Type A personality had 2X risk of stroke
• Stress can increase blood pressure and lead to hormonal changes that may increase clotting risk
• Sleep apnea (snoring, breath gasping, awakening tired) may increase risk by 2-4X. Consider sleep study if you have these symptoms
Next Steps

• What has this made you think about?
• Is there anything you will do differently in the future now that you’ve had a stroke?
• How will you go about doing this? What is the support and resources you need to accomplish this?