

STROKE REHABILITATION

The admission assessments are based on Canadian Best Practice Guidelines and are designed to promote timely treatment, enhance quality of care, optimize patient outcomes and support effective transition/discharge planning.

STROKE REHABILITATION
ADMISSION ASSESSMENT

PROCESS	INITIAL ASSESSMENT OF REHABILITATION NEEDS
<p>NURSING ASSESSMENT (OBSERVATIONS/ MEASUREMENTS)</p>	National Rehabilitation Reporting System initiated (FIM)
	Skin Integrity Assessment (Braden Assessment)
	Conley Fall Assessment
	Assess for venous thromboembolism (VTE) prophylaxis
	Depression Screen (HADS or SAD-Q-H-10)
	Transfer, Lift and Repositioning (TLR) assessment/ Logo in place
	Bowel/Bladder Assessment
	Oral Care Assessment
	Goals/Plan of Care/ Interventions
<p>OT ASSESSMENT (OBSERVATION/ MEASUREMENTS)</p>	National Rehabilitation Reporting System initiated (FIM)
	Fatigue Assessment
	ADL Assessment
	Seating Assessment
	Functional Mobility Assessment
	Upper Extremity Assessment

	Cognitive Assessment
	Visual and Perceptual Assessments
	IADL assessment
	Driving Status Reviewed
	Goals/Plan of Care/ Interventions
PT ASSESSMENT (OBSERVATION/ MEASUREMENT)	National Rehabilitation Reporting System initiated (FIM)
	Mobility Assessment (bed mobility, transfers, ambulation, stairs)
	Strength and ROM assessment
	Balance Assessment
	Neurological Assessment (reflex, coordination, proprioception, sensation)
	Tone Assessment
	Motor Control Assessment
	Goals/Plan of Care/Interventions
SLP ASSESSMENT (OBSERVATION/ MEASUREMENT)	National Rehabilitation Reporting System initiated (FIM)
	Swallowing Assessment (TORBSST, bedside Ax, MBS)
	Communication Assessment (speech and language)
	Oral Care Assessment/Management
	Goals/Plan of Care/Interventions
DIETITIAN ASSESSMENT (OBSERVATION/ MEASUREMENT)	Nutritional Assessment
	Dietary Recommendations (oral/enteral)
	Assess need for menu assistance
	Monitor Intake/ Weight/ Nutrition lab markers
	Goals/Plan of Care/Interventions

Health PEI

One Island Health System



SOCIAL WORKER ASSESSMENT	Psycho-Social Assessment
	Level of care screen
	Goals/Plan of Care/Interventions
PSYCHOLOGICAL SUPPORT	Consult Neuro/clinical psychology and/or Psychiatry as appropriate
PATIENT SAFETY	Implement safety precautions into patient's individualized plan of care

STROKE REHABILITATION TRANSITION PLANNING	
PROCESS	
TRANSITION PLANNING	Ongoing interdisciplinary team discussions regarding appropriateness/ readiness for discharge
	Patient and family conference complete
	Follow-up appointments (medical, PT, OT, SLP, etc) as appropriate
	Follow-up tests (lab and DI) considered and requisitions completed
	Information about medications provided
	Equipment recommendations/prescription provided
	Home assessment completed as appropriate
	Financial resources explored (insurance/funding sources)
	Referrals to community resources considered (if applicable)
	Driving status reviewed (provide copy of the Driving Restrictions form to client)
	Safety strategies reviewed
	Discharge Planning powerform completed in CIS
	Hand-off provided to receiving facility/service
Discharge Information Package provided	

Stroke Dietitian

- The Stroke Dietitian covers the patients on both the Acute Stroke Unit as well as the Rehab Unit. Once transferred to the Rehab unit, the Dietitian immediately liaises with the Rehab SLP re: diet order, goals etc.
- Patients will have their initial nutrition assessment completed on Cerner on admission to the stroke unit. Nutrition care plans are updated as needed based on improvements in swallowing function / diet order, weight and lab status or if oral intake declines.
- The role of the Dietitian includes:
 - Nutrition assessment - includes evaluation and on-going monitoring of weight, lipid profile, albumin, kidney function, diabetes management etc
 - Order Pre-albumin as needed (soon to be automatic on new stroke admissions)
 - Evaluate the need for menu assistance and have food service supervisors follow up daily. Will use aphasic menus as needed
 - Observe oral intake and implement nutrition interventions as required
 - Modify diet order as needed in collaboration with SLP, Nursing, O.T etc.
 - Monitor weight and nutrition lab markers
 - Nutrition education

Nursing Admission Assessments for Stroke Patients:

All new stroke admissions and transfers will be approved by the Physiatrist/delegate. Patient admission/transfer will be completed whenever the bed becomes available. The patients chart will be reviewed and report/hand-off will be obtained from the sending unit. Nursing staff of Unit 7 will:

- Complete unit orientation/tour
- Provide admission package and review patient education materials within the package
- Discuss safety precautions/falls prevention
- Review therapy schedule and whiteboards
- Document in a progress note

Complete Assessments:

Braden Assessment- Use the Clinical Information System (CIS) powerform and order the appropriate corresponding powerplan for the interventions required.

Conley Falls Risk Assessment- Use the CIS powerform to complete the Conley Falls Risk Assessment. Based on the score, complete the appropriate interventions eg. purple bracelet, bedside logo, and bedside interventions.

TLR Assessment- Complete the TLR assessment as outlined in the CIS powerform. Assign appropriate logo and indicate specific transfer instruction (eg. Hemisling, 2 wheeled walker, etc.) in the CIS order and on the TLR logo.

FIM Assessment- On the first full day of Rehab complete bathing, dressing, grooming, toileting, bowel and bladder components of the initial FIM assessment. Document in CIS powerform.

Bowel and Bladder Assessment- Assess patients elimination using the Bowel and Bladder protocol. Identify nursing interventions and include them in a plan of care.

Swallowing Assessment- Review patient's chart, check diet orders and any feeding recommendations from SLP, assess level of assistance required. Provide meal observation and provide necessary cuing to manage safe swallowing.

Oral Care- Assess level of assistance required and provide oral care as per the Oral Care Protocol for stroke patients.

VTE Prophylaxis- Assess patient's orders, medication list and mobility status and discuss VTE prophylaxis with the attending physician.

Pain Assessment- Assess the patient's pain and document on the focused assessment in CIS. Consult with attending physician and treat pain symptoms with the appropriate medication and other non-pharmacological interventions.

HADS/SADQ-H-10 Depression Screening- On transfer to Rehab complete a depression screening for all patients admitted with stroke. Apply appropriate intervention according to the protocol.

- Develop an individualized plan of care for nursing interventions
- Participate in patient and family conferences
- Contribute to weekly bullet rounds
- Lead weekly team conference
- Complete the nursing section of the "Stroke Patient Education". Document on the CIS education powerform
- Provide patient discharge education (medication, falls prevention, secondary prevention, etc)

Occupational Therapy Initial Stroke Assessment - Rehabilitation Unit

- Review clients chart
- Clients coming from the Provincial Stroke Unit often have their seating set up, it's important to check this on the morning of admission, if they are not they need to be assessed and seated in an appropriate system.
- If a client was receiving ADL programming prior to coming to Unit 7 it's important that this is carried on, with their consent, on their initial morning on the rehab unit.
- Clients coming to the Provincial Stroke unit also often have an initial assessment completed on Cerner by the Provincial Stroke Unit OT. We often refer to this during our initial interview. Assessments completed on the Provincial Stroke Unit can be re-administered (as appropriate) and can provide you with information on any improvements or decline in function. Assessments completed (or to be completed) include:
 - Functional assessments: ADLs (bathing, dressing, toileting, grooming) and functional transfers.
 - Upper extremity assessments: Motor recovery (Chedoke-McMaster Impairment Inventory for arm, hand, and shoulder pain), strength (general muscle groups muscle tested, dynamometer, pinch meter), sensation (proprioception, stereognosis, light touch, hot/cold, etc), dexterity (9 hole pegboard test, Box & Block test), ROM (passive and active), tone (Modified Ashworth Scale), and general functioning (CAHAI-8. Action Research Arm Test)
 - iADL assessments: medication management, kitchen assessment, financial management, pre-driving measures etc.
 - Cognitive assessments: MoCA, MMSE, UFOV, Multiple Errands Test, etc.
 - Perceptual assessments: Sunnybrook Neglect Battery, OT-APST, MVPT, etc.
 - Fatigue severity scale
 - Initial FIM needs to be completed within 72 hours of admission – OT fills out on the paper record (on paper chart) if client wear's eyeglasses (#79), their orientation (#60) and financial management skills (#68). On Cerner (under FIM document) we are responsible for upper body dressing, lower body dressing, toilet transfers, tub transfers, social interaction, problem solving and memory section of the FIMs. The component of the Cerner FIM is completed on admission, weekly when on rehab (done on Tuesday by the end of the day), and at time of discharge.
- After the rehab initial assessment is completed, goal setting is completed with the client.
- Interventions may include:
 - ADLs retraining
 - Upper Extremity retraining
 - Functional transfers retraining

- Wheelchair mobility
- Cognitive rehab
- Perceptual rehab
- Energy conservation
- iADL retraining
- Discharge planning – equipment recommendation, equipment set-up, home visits, follow-up

Other Duties/Assessments Beyond Basic OT Programming:

- Scheduling of client appointment times each AM
 - Fill in appointment times on the main white board and also on the porter schedule. Also need to fill in the OT assistant sheet to book therapy assistants for times you are double booked (have one OTA in the AM, two OTA's in the afternoon).
 - Highlight (with yellow highlighter) new or changed appointment times on porter schedule (from the previous day) so that the porter will know to update the white boards in the client's room
 - On porter schedule (beside their name) mark if the client is on isolation precautions, are walking up to therapy (either independently or with porter/volunteer), or if they have a watchmate on.
 - Liaise w/ PT/SLP etc to adapt times that work for all involved; check main white board to see if patient has other appointments that day
- Stroke Education
 - OT printed power point presentation to be presented to client &/or their family as deemed appropriate during their stay on Rehab. Also share a copy of "Your Stroke Journal" publication from the Heart and Stroke Foundation (found in the break room on Unit 7) if they haven't yet received one.
 - Stroke Education power form to be filled out on Cerner to chart same
- Bullet Rounds
 - Held on Unit 7 in nursing charting room on Wednesdays at 3:00.
- Weekly interdisciplinary rounds
 - Held in Classroom H on Thursday mornings from 8:00 AM to 10:30 AM
 - Blue and Green teams (the stroke teams) alternate who starts rounds monthly
- Family Conferences
 - Generally held on Thursday mornings at either 10:30 or 11:15.
 - Dates/times set during Weekly rounds and will be posted on main white board

- Teleconferences
 - To be set up if a patient will be referred to the District West Stroke Team upon discharge.
 - Contact Ruth Mills (RN) to set up time/date for conference.
 - Client/family always welcomed (and strongly encouraged) to attend so they can meet future team/therapists.

- Outpatient referrals
 - Referrals can be made to District Ambulatory Stroke Rehab teams (East Team for individuals living in Queens of Kings County or West Team for individuals living in Prince County) or Provincial Stroke team.
 - Typically it's the District team when you are recommending ongoing therapy, versus the Provincial team if it's just a consultation.
 - There's a specific outpatient referral form to be completed for Provincial and District services. These forms are often completed by the client's entire stroke team – so OT, PT, and SLP will all share the form
 - Completed referral forms to go to Ruth Mills in Provincial Clinic office
 - The same form can be used to refer the client to the Provincial Ambulatory Stroke Clinic if District services are not appropriate

- Other Discharge Planning responsibilities (as appropriate):
 - Home visits if within a reasonable distance from the QEH, otherwise a referral to Home Care OT would be the most appropriate
 - Equipment recommendation forms (and quotes as necessary)
 - Red Cross Equipment Loan Pool in Charlottetown
 - East Prince Equipment Loan Pool in Summerside for Prince County East
 - Home Activity Program
 - Fill out Discharge Planning Summary on patient's online chart
 - Functional status at time of discharge (ADLs, transfers)
 - Occupational Therapy recommendations including date/time of follow up appointments or if they will be called with appointment times

Physiotherapy Initial Stroke Assessment – Rehabilitation Unit

- Review patients chart to look for relevant history of present illness, past medical history, contraindications (e.g. weight bearing or ROM restrictions), social history, most up to date nursing and physicians documents to note necessary vital signs/blood gasses/lab values, previous PT notes, etc.
- If available, review Dr. Harrison's Psychiatry Consultation note and a Neurologists note as able.
- Assessments include (but may not be completely limited to):
 - Subjective patient interview to get information on social history/home set up (e.g. stairs, prior level of mobility, prior use of gait aids, social supports, home care prior to admission etc), pain (use Numeric Rating Scale [0-10 scale] to have patient's rate pain), general health, and goals for rehab.
 - NRS Data Questions (asked on initial assessment **AND** at discharge):
 - Do you have pain? If yes, is it mild, moderate or severe? If yes, does it affect most, some, a few or none of your activities?
 - How would you rate your general health today? Excellent, Very Good, Good, Fair or Poor?
 - Basic observation of posture (including noting shoulder subluxation), lines/tubes, speech/language abilities, orientation, handedness, bruising or other notable wounds, neglect, swelling/edema, etc
 - Range of motion (passive &/or active)
 - Measure using goniometer as appropriate/indicated
 - Strength
 - Using Manual Muscle Testing grading system
 - Sensation
 - Hot/Cold, Sharp/Dull, Light Touch, etc
 - Coordination
 - Finger/Nose, Finger Chase, RAM for U/E & L/E, Heel/Shin
 - SARA coordination assessment less commonly used)
 - Proprioception
 - Reflexes
 - Tendon and primitive reflexes
 - Tone
 - Using Modified Ashworth Scale to grade same
 - Mobility
 - Bed mobility (rolling, up/down, scooting, bridging, etc)

- Transfer ability (lying ↔ sitting, sitting ↔ standing, bed ↔ wheelchair, floor recovery as applicable)
 - Enter order [Transfer (TLR) order] to communicate with nursing staff recommended transfer method for transferring to/from bed and/or wheelchair (amount of assistance, any devices used, any special instructions, etc).
- Occasionally, as appropriate, the Elderly Mobility Scale will be used to assess patient's overall functional mobility level
- Ambulation (noting distance, gait aid used [cane vs walker vs hand hold assist, need for AFO or Dictus brace, etc], level of assistance required, gait pattern)
 - Could assess gait formally using Gait Lab Analysis system as appropriate
 - Most common outcome measures used include: TUG, 10m Walk Test, and 6 Minute Walk Test
 - Other outcome measures can include: Dynamic Gait Index, Tinetti Balance tool, others as appropriate
 - Make recommendation of initial gait aid, level of assistance required, and distance able to walk. Enter this information into an order to allow for communication with nursing staff (will frequently verbally pass this information on to patient's nurse as well).
- Stairs
- Balance
 - Basic screening of static and dynamic sitting and standing balance
 - Outcome measures can include the following:
 - Berg Balance Test (most common)
 - TUG (most common; see also under Ambulation assessment)
 - Community Balance and Mobility Scale (less common)
 - Mini BEST test (less common)
 - Function in Sitting Test (less common)
 - More informal high level standing (or sitting) balance assessment
- Motor Control using Chedoke-McMaster Stroke Assessment
 - PT usually only responsible for leg & foot; OT will most often assess U/E.
- Interventions may include (but are not limited to):
 - Range of motion exercises (passive &/or active)
 - Lower extremity retraining programs
 - Bed mobility and functional transfer retraining (rolling, lying ↔ sitting, sitting ↔ standing, etc)
 - Gait retraining (gait pattern retraining, gait speed improvement, gait aid progression and recommendation of appropriate gait aid)

- General strengthening programs
- Aerobic reconditioning programs
- Balance retraining
- Stairs retraining
- Neuromuscular stimulation for muscle activation/strengthening
- Education for patient &/or families, including stroke specific education
- Discharge planning (recommendation of appropriate aids/supports, referral to outpatient, home visits, provision of home exercise programs, etc)

Other Duties/Assessments beyond Basic PT Assessment:

- Scheduling of patient appointment times
 - Fill in appointment times on the main white board and porter schedule
 - Highlight new (or changed) appointment times on porter schedule so that porter will know to update white boards in patient's room
 - On porter schedule beside the patients name in their appointment time(s), mark if patient is on isolation precautions, are walking up to therapy (either independently or with porter/volunteer), or if they have a watchmate on.
 - Generally, new or changed appointment times marked in red on main white board, standard appointment times in black
 - Liaise w/ OT/SLP etc to adapt times that work for all involved; check main white board to see if patient has other appointments that day
- Score FIM
 - Initial FIM to be entered within 72 hours of pts arrival on Rehab Unit. If pt arrives on a weekend, same needs to be entered by end of day on the following Monday, but entered for the date of admission and scored based on how the patient was doing on the day of admission.
 - PT is responsible for:
 - Walking/Wheelchair (will often liaise with OT teammate if pt will predominantly be a wheelchair mobilize) and Stairs
- NSR Data Forms
 - On the Green ADMISSION RECORDING FORM, PT is responsible for:
 - 12: Pre-Hospital Living Arrangements
 - 14: Pre-Hospital Living Setting
 - 16: Informal Support Received
 - 17: Pre-Hospital Vocational Status

- 39: Date of Onset
- 52 & 53 (Locomotion – walking/wheelchair and stairs as above)
- 59: Impact of Pain
- 70: General Health Status
- On the Blue DISCHARGE RECORDING FORM, PT is responsible for:
 - 13: Post-Discharge Living Arrangements
 - 15: Post Discharge Living Setting
 - 16: Informal Support Received
 - 18: Post-Discharge Vocational Status
 - 32: Referred to (do not need to code, just need to write out who or where they are referred, e.g. District Stroke follow up).
 - 52 & 53 (Locomotion – walking/wheelchair and stairs as above)
 - 59: Impact of Pain
 - 70: General Health Status
- Stroke Education
 - PT Power Point presentation to be presented to patient &/or their family as deemed appropriate during their stay on Rehab.
 - Stroke Education power form to be filled out on Cerner to chart same
- Bullet Rounds
 - Held on Unit 7 in nursing charting room on Wednesdays at 3:00.
- Weekly interdisciplinary rounds
 - Held in Classroom H on Thursday mornings from 8:00 AM to 10:30 AM
 - Blue and Green teams alternate who starts rounds monthly
- Family Conferences
 - Generally held on Thursday mornings at either 10:30 or 11:15.
 - Dates/times set during Weekly rounds and will be posted on main white board
- Teleconferences
 - To be set up if a patient will be referred to the District West Stroke Team upon discharge.
 - Contact Ruth Mills (RN) to set up time/date for conference.
 - Patient/family always welcomed (and strongly encouraged) to attend so they can meet future team/therapists.
- Gait Rounds
 - Held as needed on Thursday's at 1:30 with Dr. Harrison and Marla Simpson (orthotist).
 - Tell Charlene if an appointment was made during weekly rounds for a patient to be seen in gait rounds that day.

- Outpatient referrals
 - Referrals can be made to District Ambulatory Stroke Rehab teams (East Team for individuals living in Queens of Kings County or West Team for individuals living in Prince County)
 - Typically referrals go to the District team when you are recommending ongoing therapy, versus the Provincial team if it's just a consultation.
 - There's a specific outpatient referral form to be completed for Provincial and District services. These forms are often completed by the client's entire stroke team – so OT, PT, and SLP will all share the form.
 - Same form can be used to refer patients to the Provincial Ambulatory Stroke Clinic if District services are not appropriate.
 - Completed referral forms to go to Ruth Mills in Provincial Clinic office

- Other Discharge Planning responsibilities (as appropriate):
 - Home visits (within a reasonable distance from QEH)
 - Equipment recommendation forms (and quotes as necessary)
 - Red Cross Equipment Loan Pool in Charlottetown
 - East Prince Equipment Loan Pool in Summerside for Prince County East
 - Home Exercise Program
 - Fill out Discharge Planning Summary on patient's online chart
 - Appropriate ADLs (e.g. mobility status) at discharge
 - Physiotherapy recommendations including date/time of follow up appointments or if they will be called with appointment times

- Muscle Stimulation
 - There is a post-Botox stimulation protocol being developed currently (as of June 2018). At present, it is recommended for muscle stimulation to be applied to the agonists (muscles injected) and their antagonists for 30 min, three times/day for 3 days. PT is responsible for helping to set this up and ensure nursing staff know how to help perform it in the evenings and/or on the weekends as necessary.
 - May also help to set up muscle stimulation programs to various muscle groups (e.g. around hemiplegic shoulder, wrist flexors &/or extensors, dorsiflexors, etc) as appropriate, via both NMES and/or FES (Bioness L300 system).

Social Work

When stroke patient transferred to rehab unit;

- review chart
- consult with rehab team members including physicians, nursing, PT, OT, SLP, psychology
 - meet with patient and with family to provide information, support, and to determine patient/family goals
 - psychosocial assessment - assessing a patient's mental and social well being, and ability to function and cope in the community; identifying resources/needs including financial, family support, community supports, etc.
- stroke education: Emotional Issues and Coping After Stroke
 - Seniors Functional Assessment (SAST) completed as needed/appropriate (for placement to community care or long term care after hospitalization)
 - liaise / collaborate with appropriate community agencies - Disability Support Program, Income Support, private insurers, etc and complete referrals for patients to access needed resources, including financial, home supports, mental health counseling

Speech-Language Pathology Protocol

- Review patient's chart
- Patients coming from the Provincial Stroke Unit (PSU) have had a formal bedside swallowing assessment completed by the PSU SLP and the safest diet for patient has been recommended. It is important for the Rehab SLP to review the patient's oropharyngeal swallowing function at the time of admission to determine if patient is considered appropriate for a diet and/or fluid upgrade or if patient should remain on their current diet modifications. (See swallowing assessment protocol)
- Patients coming from the Provincial Stroke Unit should have a standardized speech-language screen completed (documented on Cerner) by the Provincial Stroke Unit SLP. The standardized screening tool is called the Western Aphasia Battery-Screening Tool (WAB-Screener). The Rehab SLP will often refer to this during the initial interview. The results of this standardized screen will assist the Rehab SLP in completing a full formal speech-language assessment.

Steps to complete a standardized Speech-Language Screen:

- 1) Complete a full case history
- 2) A standardized speech-language screening tool should be administered to screen patient's speech-language skills within 36 hours of onset, when the patient is awake and alert (Canadian Stroke Best Practice Guidelines). The standardized screening tool used at the QEH is the Western Aphasia Battery-Screening Tool.
- 3) If the WAB-Screen has not yet been completed, the Rehab SLP will complete the screening process. A bedside aphasia score is calculated.
- 4) Following review of the bedside aphasia score on the WAB-Screen, the Rehab SLP will determine the presence or absence of speech-language impairments. In the presence of speech-language impairments, a full formal speech-language assessment will be completed

Full Formal Speech-Language Assessment:

Standardized assessment batteries that are administered (or to be completed) include:

Language:

Western Aphasia Battery- Revised (formally evaluates expressive and receptive language skills)

The Boston Naming Test

The Test of Adult/Adolescent Word Finding

Subtests of the Cognitive Linguistic Quick Test (to assess higher-level cognitive-linguistic domains of language. ****NOTE:** The Rehab SLP will typically collaborate with the Rehab OT to review patient's higher-level cognitive linguistic skills (e.g. working memory, attention, higher level language processing, etc.)**

Reading Comprehension Battery for Aphasia (RCBA)

Motor Speech:

The Apraxia Battery for Adults

Subtests of the Frenchay or the Assessment of Intelligibility of Dysarthric Speakers (AIDS)

Speech-Language Pathology Interventions:

Interventions may include:

- Language therapy (for language impairments such as non-fluent, fluent and global aphasia)
- Motor speech therapy (for motor speech disorders such as dysarthria, apraxia).
- Swallowing therapy (for dysphagia)

Patients are typically scheduled for 2 30 minute sessions of SLP intervention on the Rehab Unit (this may fluctuate depending on the severity of patient's impairments. *For example:* a patient with mild-moderate dysarthria may only have speech therapy 1x/day and gradually downgrade to 3x/week with home programming as well).

Other Duties/Assessments Beyond Basic SLP Programming:

- Scheduling of patient appointment times each AM in collaboration with OT, PT and Nursing:
 - Fill in appointment times on the main white board by the Nursing Station and also on the porter schedule.

- Highlight (with yellow highlighter) new or changed appointment times on porter schedule (from the previous day) so that the porter will know to update the white boards in the patient's room
 - On porter schedule (beside their name) mark if the patient is on isolation precautions, are walking up to therapy (either independently or with porter/volunteer), or if they have a watchmate on.
- Stroke Education
 - SLP will meet with patient and patient's family/caregivers during one of the early/initial sessions with patient to review patient's communication and/or swallowing following their stroke. Rehab SLP ensures that the information is pertinent and specific to the type of stroke the patient sustained and the specific impairments the patient has endured. Also share a copy of "Your Stroke Journal" publication from the Heart and Stroke Foundation (found in the break room on Unit 7) if they haven't yet received one.
 - Stroke Education power form to be filled out on Cerner to chart same
 - Bullet Rounds
 - Held on Unit 7 in nursing charting room on Wednesdays at 3:00.
 - Weekly interdisciplinary rounds
 - Held in Classroom H on Thursday mornings from 8:00 AM to 10:30 AM
 - Family Conferences
 - Generally held on Thursday mornings at either 10:30 or 11:15.
 - Dates/times set during Weekly rounds and will be posted on main white board
 - Teleconferences
 - To be set up if a patient will be referred to the District West Stroke Team upon discharge.
 - Contact Ruth Mills (RN) to set up time/date for conference.
 - Patient/family are always welcomed (and strongly encouraged) to attend so that they can meet their future team/therapists.
 - Outpatient referrals

- Referrals can be made to District Ambulatory Stroke Rehab teams (East Team for individuals living in Queens or Kings County; West Team for individuals living in Prince County) or Provincial Stroke team.
 - A specific outpatient referral form should be completed for Provincial and District services. These forms are often completed by the patients's entire stroke team – OT, PT, and SLP will all complete this form
 - Completed referral forms to go to Ruth Mills in Provincial Clinic office
 - The same form can be used to refer the patient to the Provincial Ambulatory Stroke Clinic if District services are not appropriate
- Other Discharge Planning responsibilities (as appropriate):
 - Providing education to staff/caregivers/family members, where patient will be discharged on communication and/or swallowing strategies
 - Home Programs
 - Fill out Discharge Planning Summary on patient's online chart
 - Diet/fluid modifications and recommendations
 - Speech Language Pathologist's recommendations for continued intervention or follow-up including date/time of follow up appointments or if they will be called with appointment times

Swallowing Assessment Protocol:

- 1) Case history: obtain a complete case history from patient's chart (e.g. physician admission history & physical reports, emergency dept. documentation, Dr. Harrison's report, nursing notes, etc.)
- 2) Perform a formal **Bedside Swallowing Assessment**
 - a. This will be completed after a standardized swallowing screening assessment has been completed by nursing staff. The swallowing screening tool used at the Queen Elizabeth Hospital in Charlottetown, PEI, is called the TOR-BSST (Toronto Bedside Swallowing Screening Tool). If the patient fails the TOR-BSST, the SLP is consulted and a formal bedside swallowing assessment is completed. Steps for formal bedside swallowing assessment are listed below:
 - i. Oral motor examination
 - ii. Trial various textures and consistencies at bedside to evaluate patient's oropharyngeal swallowing function and to determine the presence of any clinical signs or symptoms (s/s) of dysphagia (e.g. oral weakness, labial spillage, difficult mastication, aspiration, etc.)
 - iii. Determine the following:
 - iv. Is patient considered safe to begin a regular diet with regular fluids, or will the patient require texture and/or fluid modifications?
 - v. Determine if a **Modified Barium Swallow (MBS) Study** is required:
 1. The patient demonstrated clinical s/s of aspiration at bedside
 2. The patient complains of structural abnormalities or difficulties that the SLP is not able to identify at bedside (e.g. globus sensation, a blockage/narrowing, etc.
 3. The patient has a tracheostomy, and it is unclear at bedside if the patient has aspirated.
- 3) IF a decision is not able to be made following a Bedside Swallowing Assessment (due to aforementioned situations) a MBS will be ordered.
 - a. Place a suggest order to the attending physician, stating the rationale for completing the MBS.
 - b. Following physician's order of the MBS, schedule the MBS in Diagnostic Imaging (DI)
 - c. Complete the MBS in DI.
 - i. Analyze MBS video to objectively evaluate patient's oropharyngeal swallowing function. Make appropriate recommendations for patient's diet.

- ii. Communicate SLP recommendations to the Rehab Team (e.g. Attending physician, Clinical lead RN, patient's nurse, Registered Dietitian (RD), etc).
 - iii. Adjust patient's diet. Collaborate with RD.
- 4) Initiate Swallowing Therapy as required
- 5) Complete daily observations of patient's swallowing function in the dining room on the Rehab Unit. Determine if and when pt. is considered safe and appropriate for a meal observation in order to determine if pt's diet may be upgraded.
- 6) **Oral Care.** The Rehab SLP works in collaboration with Nursing staff to ensure that proper oral care is effectively completed for patients (mild, moderate, severe, profound dysphagia, patients with tube feeds, etc.), oral musculature weakness, left or right neglect, etc.

Depression Screening Protocol

Complete screening at each transition and when clinically indicated (evidence of depression or change in mood)

Process:

- On day 2 of Rehab (day after admission/transfer) complete depression screening using (HADS/SADQ-H-10)
- Document results on CIS
- Report findings to attending physician
- Report findings at weekly team conference
- Intervention:
- HADS:
- Total Score 0- 7: Continue to monitor for changes in mood
- Total Score 8 -10: Consider referral to SW/ spiritual care/ for [counseling] support
- [Provide patient education using “Your Stroke Journey” or Stroke Engine handout – I moved this to the 8-10 score range]
- Total Score 11 or greater, or D score of 8 or greater: Discuss with MD and/or Psychologist on Unit. Consider pharmacotherapy and possible referral to Psychology

SAD-Q-H-10:

- 0-5: continue to monitor for changes in mood
- 6+: Discuss with MD on Unit, and consider pharmacotherapy or other interventions as appropriate.