What is Stroke Distinction?

The Accreditation Canada Stroke Distinction program was launched in March 2010 The comprehensive Stroke Distinction program was developed in partnership with the Canadian Stroke Network (CSN) and incorporates standards of excellence, *Canadian Best Practice Recommendations for Stroke Care* (strokebestpractices.ca), and in-depth, stroke-specific performance indicators and protocols. An on-site visit is conducted by expert evaluators with extensive practical experience in stroke services.

Following the successful completion of the Stroke Distinction process, the organization receives a Stroke Distinction Award that is valid for four years. At the end of the four years, the organization begins a new distinction cycle.

To participate in the Stroke Distinction program, an organization must already be accredited through the Qmentum accreditation program and also have a dedicated stroke services program or unit and dedicated stroke services staff.

Accreditation Canada checks the following to determine whether Stroke Distinction will be awarded:

1. The degree of compliance with the standards
2. The achievement of performance indicator thresholds
3. The implementation of stroke protocols or clinical practice guidelines
4. Commitment to excellence and innovation
5. Commitment to client and family education

Standards of excellence

The standards of excellence for the Stroke Distinction program are based on the Canadian Stroke Strategy's *Canadian Best Practice Recommendations for Stroke Care*. There are three sets of standards in the Stroke Distinction program:

1. *Standards for Providing an Integrated System of Services to People with Stroke*

   These standards would be used in a regional setting where services are coordinated for a variety of sites (acute and rehabilitation) that report to a Regional Health Authority.

2. *Standards for Acute Stroke Services*

   These standards would be used by sites that provide acute stroke services and that have a defined service boundary or catchment.

3. *Standards for Inpatient Stroke Rehabilitation Services*

These standards would be used by sites that provide inpatient stroke rehabilitation services and that have a defined service boundary or catchment.

Our HPEI Organized Stroke Care Program (HPEI OSCP) will be assessed on all three sets of standards.

Performance Indicators

Throughout the Stroke Distinction process, client organizations are required to collect and submit data for all **core indicators** and two of the **optional indicators**. They must also meet minimum performance thresholds for the following:

- Seven of nine acute stroke services core performance indicators

- Three of four inpatient stroke rehabilitation services core performance indicators

Where performance indicator thresholds are not met, an action plan with performance targets is developed to guide improvement. Furthermore, indicator data must be regularly submitted between onsite surveys. See Appendix A for Core Indicators and Appendix B for Optional Indicators.

Teams will be given feedback regarding the indicators that apply to them and the teams will develop plans for ongoing quality improvement.

Protocols

Implementing stroke protocols is a key component of excellence in stroke services. Using protocols helps stroke services remain consistent, high quality, and evidence based. There are 14 protocols that apply to the hyperacute/ acute stage of care and 6 that apply to inpatient rehabilitation care. See Appendix C.

To achieve an award of Distinction, organizations must ensure that 60% of the protocols are adopted and implemented by stroke services.

The HPEI OSCP has implemented all of the required protocols. We will need to provide evidence that they are being utilized as intended.

Excellence and Innovation

Excellence and innovation are key components of effective stroke services. The Accreditation Canada programs support excellence and innovation by requiring that organizations demonstrate the full implementation of projects or initiatives that align with best practice guidelines, and that they use the latest knowledge and integrate evidence to enhance the quality of stroke services. Examples include projects that improve communication at transition points, bolster the delivery of comprehensive patient care, and address tissue plasminogen activator (tPA) rates and response times.

Each organization or stroke network (regardless of the number of sites) is expected to choose one to two stroke projects that meet the criteria below. The project will be evaluated as part of the on-site visit to assess whether it:

- Is evidence based e.g. aligned with accreditation standards and current *Canadian Best Practice Recommendations for Stroke*
- Adds to the overall quality of stroke services within the facility or region
- Includes a completed evaluation, and measures sustainability of the project or initiative
- Communicates findings within the organization and externally
- Is notable for what it could contribute to the delivery of stroke services

The HPEI OSCP has chosen our Telestroke Rehabilitation Program as our special project to demonstrate innovation and excellence.

Client and family education

Client, family, and caregiver education is an integral part of stroke care and should be addressed across the continuum of stroke care. Education is an ongoing and vital part of the

recovery process for stroke, and must reach the survivor, family members, and caregivers; education about stroke supports coping and self-management. Skills training for clients and caregivers reduce depression and the perceived burden of stroke, and improve the stroke patient's quality of life. The information provided at each phase of acute care, rehabilitation, community reintegration, and long-term recovery should be relevant to the client's and the family's changing needs. Simply distributing information is not sufficient; instead, client education must be interactive. During the on-site visit, each site seeking Stroke Distinction must provide the evaluators with evidence of successful client and family education. The educational capacity of organizations will be evaluated based on the following elements:

- Client educational materials are available and accessible on the ward
- Client educational materials are available in a variety of languages appropriate to the client population mix
- Client educational materials are available in formats that are appropriate for persons with special communicative needs
- In interviews with clients and family members during tracers, clients report receiving education regarding their stroke, recovery, and self-management from the healthcare professionals that care for them
- Standardized tool used to document components of education provided to ensure all critical elements addressed prior to client discharge
- Consistent location in client chart for documentation of education provided
- Documentation of education provided by each healthcare profession involved in the client's care within the discipline notes or common progress notes
- Documentation of specific content addressed during an educational session (e.g., skills taught and demonstrated, discharge preparation, etc)

Currently (November 2017) the Stroke Education working group is reviewing the state of stroke education across the continuum. We have a provincially approved online education charting form capable of capturing multiple encounter information regarding the types and responses to the education being provided.

Appendix A: Stroke core performance indicator thresholds

Indicator	Threshold
Stroke / transient ischemic attack (TIA) mortality rates	30 day in hospital all-cause mortality < 22% of all stroke/TIA admissions
Proportion of ischemic stroke clients who receive acute thrombolytic therapy (tPA)	7% of all ischemic stroke clients, regardless of time from stroke onset to tPA administration
Median time to administration of acute thrombolytic agent	50% of all tPA clients have door-to-needle time of < 60 minutes
Proportion of clients treated on stroke unit	Proportion of stroke clients managed on an acute stroke unit or integrated stroke unit for some part of acute inpatient stay ≥ 75% Proportion of stroke clients managed on an

	inpatient rehabilitation stroke unit for some part of inpatient rehabilitation stay ≥ 80%
Proportion of clients treated on a unit where stroke clients are clustered meet all other 'stroke unit' criteria	Proportion of stroke clients managed on a clustered section of an acute inpatient hospital ward specifically for stroke clients for some part of acute inpatient stay ≥ 75%
	Proportion of stroke clients managed on a clustered section of a rehabilitation hospital ward specifically for stroke clients for some part of inpatient rehabilitation stay ≥ 80%
Length of stay in an acute care hospital setting for clients admitted following an acute stroke event	Median acute services total length of stay ≤ 14 days
Length of stay in an inpatient rehabilitation setting for clients admitted following an acute stroke event	Median total rehabilitation length of stay ≥ 14 days
Readmission to acute care for stroke-related causes	90 day readmission rate to acute services for stroke related causes ≤ 12%
Proportion of acute stroke clients discharged to inpatient rehabilitation	Proportion of stroke clients admitted to inpatient rehabilitation ≥ 15% of all acute ischemic and hemorrhagic stroke clients discharged alive from acute care

Appendix B: Optional stroke performance indicators

Proportion of clients who receive acute ASA therapy within the first 48 hours of hospital arrival

Proportion of acute stroke and TIA clients who receive brain CT or MRI within 24 hours of hospital arrival

Proportion of all stroke clients who receive an initial rehabilitation assessment within 48 hours of admission

Proportion of inpatients with stroke that experience complications during inpatient stay: inducing pneumonia, venous thromboembolism, gastrointestinal bleed, secondary cerebral hemorrhage, pressure ulcers, urinary tract infection

Wait time from ischemic stroke or TIA symptom onset to carotid revascularization

Proportion of TIA or non-disabling stroke clients discharged directly from the ED who receive a referral for assessment in a stroke prevention clinic or equivalent before leaving hospital

Proportion of eligible ischemic stroke and TIA clients with atrial fibrillation prescribed anticoagulant therapy on discharge from acute care

Median number of days from stroke onset to admission to inpatient rehabilitation

Change in functional status from time of admission to an inpatient rehabilitation unit for stoke clients to the time of discharge, based on a standardized measurement tool score

Proportion of stroke clients with documentation to indicate screening for depression was performed either informally or using a formal assessment tool in the inpatient rehabilitation setting following an acute stroke event

Proportion of stroke clients with documentation to indicate screening for vascular cognitive impairment was performed either informally or using a formal assessment tool in the acute care or rehabilitation setting following an acute stroke event

Proportion of stroke clients admitted to inpatient rehabilitation who receive an assessment for falls risk and have it documented in their hospital record

Appendix C: Stroke protocols

Acute care protocols	**Inpatient rehabilitation protocols**
Emergency Medical Services (EMS) stroke screening	Formal intake criteria for triaging client referrals and accepting clients for inpatient rehabilitation
EMS bypass / direct transport to stroke centres (including air ambulance)	Swallowing ability assessment
EMS pre-notification of stroke	Initial assessment of rehabilitation needs
Emergency Department notification of hospital-based stroke team	Assessing and managing diabetes mellitus (when present)
Neurovascular imaging for potential stroke patients (rapid access to CT)	Pressure ulcer prevention
tPA eligibility screening (based on Canadian Stroke Strategy *Canadian Best Practice Recommendations for Stroke Care* criteria]	Falls prevention
tPA administration	
Administering acute ASA therapy	
Formal criteria for identifying appropriate clients for referral to inpatient rehabilitation	
Swallowing ability assessment	
Initial assessment of rehabilitation needs	
Assessing and managing diabetes mellitus (when present)	
Pressure ulcer prevention	
Falls prevention	