Regional Stroke Network
Réseau Régional des AVC
CHAMPLAIN

SERVICE STANDARDS FOR OUTPATIENT REHABILITATION SERVICE WITH STROKE EXPERTISE

These service standards are supplementary to the Champlain Regional Stroke Rehabilitation System and Patient Flow Algorithm and should be used to guide the provision of outpatient stroke rehabilitation within the Champlain region. These service standards are reflective of the Quality Based Procedures Clinical Handbook for Stroke (QBP, December 2015) and the Canadian Best Practice Recommendations for Stroke Rehabilitation (CSBPR, 2015) but not meant as a replacement for those two documents. Outpatient Stroke Rehabilitation programs should be familiar with and follow CSBPR and QBP. This document offers service standards for topics on which the CSBPR and QBP differ in their recommendations.

The administrator responsible for the Outpatient Stroke Rehabilitation program, together with the manager, may review these service standards on an annual basis with the Champlain Regional Stroke Network (CRSN) to develop a plan for improvement with the support of the CRSN Rehabilitation Coordinator. Recommended methods of verification for each standard are provided, as appropriate. A checklist to facilitate this review is available on the CRSN website.

1. INTERPROFESSIONAL STROKE REHABILITATION TEAM

Stroke rehabilitation in the outpatient setting is to be provided by a specialized interprofessional stroke rehabilitation team.

The core team members are:

- **Primary Care Provider**
- **Nurse**
- **Physiotherapist**
- **Occupational Therapist**
- **Speech Language Pathologist**
- **Social Worker**
- **Psychologist**
- **Dietitian**
- **Pharmacist**
- **Therapeutic Recreational Specialist**
- **Therapy/Rehabilitation Assistant** [QBP, 2015]

The patient, family, and caregiver are an integral part of the rehabilitation process and should be considered part of the team [QBP, 2015]. Expertise and core training in stroke rehabilitation is expected for all members of the core team (see Section 2.1 for more information).

2. Stroke Expertise

The CSBPR (2015) state that the interprofessional stroke rehabilitation team should have stroke expertise. This section provides the Service Standard Working Group's interpretation (2014) of *stroke expertise* and includes a list of available training/education resources, which can help team members gain stroke expertise. There is also an emphasis on continuing education.

2.1. Core Skill Sets, Knowledge & Training

The management of the Outpatient Stroke Rehabilitation program is responsible for verifying that each member on the interprofessional stroke rehabilitation team has achieved or learned the appropriate items below (in Table 1). It is the responsibility of each member on the team to ensure that they are aware of and have the appropriate core skill sets, knowledge, and training outlined in Table 1.

All members of the interprofessional stroke rehabilitation team will:

TABLE 1

Core Skill Set, Knowledge, or Training	Recommended Learning & Resources	Method of Verification/Other Relevant Information about Resource
Be knowledgeable about the disease/condition of stroke, including basic anatomy, deficits, and recovery.	i) Shared Learning Objectives for Stroke Care (SLOSC) ii) Hemispheres Stroke Competency Series iii) Educational events: - CRSN Educational Events - OSN Rounds or other webcast/webinar series - Other stroke-related discipline-specific education series	i) Use of SLOSC for needs self-assessment and to set learning objectives. ii) Participant receives a course completion certificate and/or continuing education certificate for completing the series. iii) For items iii through v – each team member should participate in at minimum one of these types of education sessions per year. The person's *professional portfolio*^ will include a list of education sessions attended. ***Verification*** for CRSN events attended can be obtained through the Education Database.
Be aware of and follow Canadian Best Practices Recommendations for Stroke Care, in Rehabilitation specifically. **Be aware of the EBRSR (Evidence-Based Review of Stroke Rehabilitation) website and use, as needed.**	i) OSN presents videoconferences when a best practice guideline is released or updated. ii) Interprofessional team can review the guidelines as a group or individually.	i) Each team member should attend or watch archived webcast of these presentations. Verification comes from the OTN/OSN sign-in confirmations. ii) Team member signs off that they have reviewed and understand the guideline.
Be aware of and be able to provide some supported communication for patients with aphasia.	i) The outpatient stroke rehabilitation service SLP can provide information about supportive communication to all core team members. ii) Supported Conversation for Adults with Aphasia (SCA):	i) Core team members have learned about supported conversation techniques for stroke patients with aphasia. ii) The outpatient stroke rehabilitation service SLP(s)

	▪ Self-directed learning module (from the Aphasia Institute) ▪ Training may be offered by an SLP who has participated in *train the trainer* program for SCA. iii) Workshop on communication deficits post-stroke.	has participated in SCA training. iii) Team members have attended communication workshop.
Understand how to administer, interpret, and apply validated assessment tools	Lists of recommended assessment tools: ▪ Best Practice Recommendations Table 5.1 ▪ StrokeEngine	Team members are familiar with and use the recommended tools when appropriate.
Have knowledge of standard outcome measures recommended for use in the Champlain region, especially domain-specific outcome measures. **Use, as appropriate, standard outcome measures.** **Be aware of the StrokeEngine website where additional assessments and tools can be found.**	Examples of recommended outcome measures: i) Chedoke McMaster – McMaster University offers a training workshop ii) Berg Balance Scale (BBS) – no formal post-licensure training A complete list can be found on the Champlain Regional Stroke Network website.	i) Certificate from McMaster ii) Team members are familiar with and use the BBS when appropriate Team members regularly use these outcome measures for stroke patients.
Be trained on or be familiar with the Functional Independence Measure (FIM) instrument*.	The Canadian Institute for Health Information (CIHI) runs a *train the trainer* program for the FIM instrument. A new employee would be trained by a staff member at their organization who participated in the train the trainer program.	Individual will receive a certificate after successful completion of FIM training. CIHI recommends annual recertification, although it is not compulsory. Facilities may decide whether clinicians are to be recertified on an annual basis.
Be trained on or be familiar with the Montreal Cognitive Assessment (MoCA)*.	MoCA website includes the test as well as instructions for use. There is no formal post-licensure training.	Team members are familiar with and use the MoCA where appropriate.
Have knowledge about interprofessional team functioning	Workshops or communication / collaboration events within your organization or department. OSN Interprofessional Collaboration references.	Group's attendance (together) at a workshop. Team members are aware of the roles of other team members. Team has implemented interprofessional functioning model in their practice.

^It is expected that all members of the interprofessional rehabilitation team maintain a professional portfolio for their colleges, which details the education they have taken throughout the year.

*Not all staff on the interprofessional stroke rehabilitation team will need to administer the FIM or the MoCA, however, it is required that these uncertified staff are knowledgeable about these two assessments.

2.2. Continuing Education

Continuing education is a key consideration for the interprofessional stroke rehabilitation team due to the frequent emergence of new evidence that results in changes to best practices in stroke rehabilitation.

- The learning needs of the team are assessed on an annual basis with gaps in knowledge addressed as they are identified.

- The team is to be engaged in continuing education year-round.
- The team follows the institution or organization's policies for continuing education, which can be verified against said policy.

Verification – Evidence that the interprofessional stroke rehabilitation team members are participating in continuing education can be found in each team members' professional portfolio.

2.3. Treatments and Therapies

The clinician may apply whatever **evidence-based** approach to therapy/treatment they consider to be appropriate for the patient as long as the following three elements are incorporated:

(1) Treatment/therapy is be direct and task/goal specific.
(2) Treatment/therapy includes repetitive and intense use of novel tasks that challenge the patient to gain the skills needed to perform functional tasks and activities.
(3) The team promotes the practice and transfer of skills to the patient's daily routine [Canadian Best Practice Recommendations for Stroke Rehabilitation, 2013].

The CSBPR provide treatments/therapies that are appropriate for stroke patients. This service standard will not prescribe specific treatments/therapies, trusting that each member of the interprofessional stroke rehabilitation team is knowledgeable in their field of practice and able to provide appropriate rehabilitation.

The interprofessional stroke rehabilitation team should encourage and help patients develop a plan for self-management. This would include education about secondary stroke prevention and discussion about return to vocation, driving, and other life roles [QBP, 2015].

Verification – Treatment/therapy provided is evidence-based and incorporates the three elements of therapy listed above. A chart audit may be completed to verify this.

3. Frequency and Intensity of Outpatient Stroke Rehabilitation Services

Stroke patients are to receive rehabilitation therapies of appropriate intensity and duration, individually designed to meet their needs for optimal recovery and tolerance levels. The patient will receive therapy that is direct and task/goal specific and provided on a one-to-one basis by the interprofessional stroke rehabilitation team.

Rehabilitation therapy in the outpatient setting will be provided primarily by Physiotherapists, Occupational Therapists, and Speech Language Pathologists. Assistants (e.g. Rehab Assistant, Physiotherapy Assistant) and other members of the interprofessional stroke rehabilitation team will also provide therapy, depending on the needs of the patient.

The amount of rehabilitation therapy provided is to be based on patient needs and goals. At a **minimum**, therapy should be provided **by each discipline (PT, OT, and/or SLP) the patient requires** for:

- 45 minutes per day [CSBPR, 2015];
- 2 to 3 times per week [QBP, 2015] and as often as 5 days per week [CSBPR, 2015];
- 8 to 12 weeks [QBP, 2015].

Verification – Random chart audit/review of patient rehabilitation sessions.

4. Service Delivery

4.1. Staffing Ratios for Outpatient Stroke Rehabilitation Services

Staffing ratios are sufficient to support the frequency and level of intensity of rehabilitation outlined above [Recommendation by Service Standards Working Group, 2014]. Acceptable staffing ratios are those that enable the outpatient stroke rehabilitation service to provide quality rehabilitative care to its stroke patients, allowing patients to meet their rehabilitation goals, achieve functional gains, and experience good outcomes.

4.2. Time to First Appointment

Outpatient stroke rehabilitation services are responsible for admitting stroke patients to the program on a priority basis. Interdisciplinary outpatient stroke rehabilitation services should be available and provided within 48 and 72 hours of discharge from acute care and inpatient stroke rehabilitation, respectively [QBP, 2015; CSBPR 2015].

4.3. Location

Outpatient stroke rehabilitation is recommended for patients who suffered a mild stroke (mild stroke indicated as an AlphaFIM® score greater than 80). Where the patient receives rehabilitation therapy (e.g. in a clinic/outpatient setting, through a home-based program, or in inpatient stroke rehabilitation) depends on program availability and the patient's ability to access outpatient stroke rehabilitation. A process to determine the appropriate sub-acute service for patients who suffered a mild stroke was recommended by the Significant Deficits Working Group (2014) and is available on the CRSN website (and hyperlinked above).

This document will be updated as new evidence, best practices, and Quality Based Procedures information are released. This document was last updated on June 17, 2016. Before using this resource, check for the most recent version on the Rehab page of the Champlain Regional Stroke Network website:

www.champlainregionalstrokenetwork.org

References:

Hebert, D & Lindsay, M P. (2016). Canadian stroke best practice recommendations: Stroke rehabilitation practice guidelines, update 2015. International Journal of Stroke, 11(4), 459-484. Available from: http://wso.sagepub.com/content/early/2016/04/14/1747493016643553.full.pdf?ijkey=UC18LzZrGBY9HZp&keytype=finite

Health Quality Ontario; Ministry of Health and Long-Term Care. Quality-based procedures: clinical handbook for stroke (acute and postacute). Toronto: Health Quality Ontario; 2015 December. 148p. Available from: http://www.hqontario.ca/Evidence-to-Improve-Care/Recommendations-and-Reports/Clinical-Handbooks-for-Quality-Based-Procedures