Quick Reference Guide: Social Work Stroke Care and Management

BACKGROUND: The Champlain Regional Stroke Network created a set of practical stroke care guidance documents to support healthcare professionals who may not be fully familiar with managing acute ischemic and hemorrhagic stroke patients. The documents are designed to be guidance rather than strict directives, meaning they are intended to support, rather than replace, the clinical judgment of individual healthcare providers. By focusing on stroke care that aligns with best practices, these resources help ensure that stroke patients continue to receive appropriate and timely treatment, despite the challenges of the healthcare system.

Acute Stroke Care Timelines (CSBPR)

Day 1

Within 24 hours:
- Complete Dysphagia screen

Day 2

Within 48 hours:
- Initiate initial assessment as soon as possible after admission
- Prior to assessment, review activity orders (e.g. bedrest after procedure such as EVT), blood pressure parameters and NIHSS.
- Initiate discharge planning

Day 3

Within 72 hours:
- Complete and document assessments to help determine type of ongoing post-acute rehabilitation needs including tolerance, participation and ability to follow direction.
- Complete AlphaFIM on or by day 3 after admission (target day 3, admission day is day 1) to hospital. You must be credentialed to complete the alphaFIM. (Reminder: patients on droplet isolation are scored as "non-walkers").

Transitions / Discharge

- Submit rehab application as appropriate. Champlain Region Stroke Landscape: *https://crsn.ca/en/about-us*
- For patients who do not initially meet criteria for rehabilitation, monitor and complete weekly reassessment of rehabilitation needs.
- Deliver timely and comprehensive information, education and skills training to all patients and their family members/informal caregivers.
- Provide every patient with a "Your Stroke Journey" booklet. *https://www.heartandstroke.ca/-/media/pdf-files/canada/your-stroke-journey/en-your-stroke-journey-v20.ashx*

Visit the CRSN website for more information: www.crsn.ca

- *To learn more on post stroke conditions and to access practice tools: https://crsn.ca/en/clinical-tools-resources*
- *For all patient handouts/infographics: https://crsn.ca/en/resources-for-stroke-care-and-recovery*

Topic	Key Messages	Where to Find More Information
Assessment	Complete full psychosocial assessment as soon as possible after admission. • Provide 'Your Stroke Journey' booklet to patient. Send link of booklet to family by email if possible. • Patients and their families should be provided with information about peer support groups in their community where available, descriptions of the services and benefits they offer, and be encouraged to consider participation. This can be found in 'Stroke Journey Booklet' and on CRSN website.	Your Stroke Journey CRSN- Stroke Survivor and Caregiver Support
Mood and Emotions Post-Stroke	Complete 'PHQ-9 Depression Questionnaire' upon admission. • All patients who have experienced a stroke should be screened for post-stroke depression, if deemed medically appropriate, given the high prevalence of post-stroke depression. A patient's whose screening indicates a high risk for depression should be assessed in a timely manner by a healthcare professional. • It is important to provide psychoeducation surrounding post-stroke depression to patients and families and for a patient's mental health to be monitored throughout the continuum of stroke care.	PHQ-9 Screen Emotions and Mood Post Stroke
Education and Self-Management	All patient's, families, and informal caregivers should receive timely, comprehensive information, education, and skills training by all team members. Examples for SW include: education around coping, supports, financial resources, and advanced care planning, as appropriate. Please see link attached for comprehensive list.	Education and Self-Management Checklist
Transitions	1. Referring to In-Patient Rehab: Once a patient's AlphaFIM (AF) is completed on Day 3: • If AF is in the range of 40-89 AND the patient is medically stable AND meets all rehab criteria - send inpatient rehab referral to appropriate program. • For patients who are not medically stable or do not initially meet criteria for rehabilitation, weekly reassessment of rehabilitation needs may be considered during the first month, and at intervals as indicated by their health status thereafter. Social work to continue to liaise	Rehab Criteria Rehab Locations (inpatient and outpatient) and Referral Process for TOH

	with multidisciplinary team re: patient's status and progress – and to apply to rehabilitation as appropriate. • Please note, the AF score is used to help guide decisions around rehabilitation. Clinical judgement and ongoing assessments from multidisciplinary team monitoring potential progress should be considered when making decision around rehab readiness and place of care. 2. Referring to Out-Patient or Community Rehab: If AF is >80 AND the patient requires SLP/OT/PT follow-up send referral to outpatient or Community rehab program based on geographic location or patient needs: • Ottawa: Bruyere Continuing Care Ambulatory Stroke Rehabilitation Clinic and Physiatry o Fast Track referral used to access Rehab and/or Physiatry services • Community Stroke Rehabilitation (AF >79) - Submit LHIN referral requesting 'Community Stroke Therapy'. Attach all relevant therapy assessments and discharge summaries with referral. - See the referral pathway algorithm to help your team select between OP services at Bruyere or CSR services. • Perth Hospital - Via direct consult with Dr. Stolee (1-613-267-1500 x2252) 3. Patient has been admitted to your facility awaiting bed at Inpatient Stroke Rehab: • It is strongly recommended that this rehab plan be followed. • Any changes to the rehab plan should be made with the input of all Allied Health professions' (i.e. SLP, PT, OT, SW). If all disciplines are not available at your facility to re-assess rehabilitation needs, then, initial rehabilitation plan should be followed.	Bruyere Fast Track Referral - Currently, physiatrists are doing phone or video initial assessments for Fast Track. There is currently NO outpatient therapy being provided. Areas served by Community Stroke Rehab: Ottawa (within municipal boundaries) United Counties of Stormont, Dundas & Glengarry counties and Akwesasne United Counties of Prescott &Russell. Renfrew County
Palliative and End of Life Care	• Social Work may be involved with patients, families, and informal caregivers with management of anxiety and depression, and preferred location of palliative care. • Supportive counselling, funeral supports, and bereavement resources should also be provided to families and caregivers as needed.	

	• Patients, families, and the health care team should have access to palliative care specialists, particularly for consultation regarding patients with difficult-to-control symptoms, complex or conflicted end-of-life decision making, or complex psycho-social family issues	

Contact Michelle Simpson, Best Practice Social Worker with the Champlain Regional Network with questions.

misimpson@toh.ca **613-798-5555 extension 18575**