Social Work Quick Reference Guide for Stroke Care - COVID-19 Pandemic

This document is intended to guide and support Social Workers who may have limited experience working with stroke patients. It provides a summary of the care guidelines and assessments required to support stroke survivors during the Acute and Rehabilitation phase of their recovery.

A. For basic information on stroke, refer to the Stroke 101 document

B. Stroke Assessment

Within 48 hours:

- ❑ Initial SW assessment **and formulation of a management plan.**
- ❑ Clinicians should use standardized valid assessment tools and functional observation to evaluate the patient's stroke-related impairments. See Canadian Stroke Best Practice screening/assessment tools recommendations.
- ❑ Refer to Social Work (SW) Stroke assessment checklist below
- ❑ Discharge planning should begin as early as possible

Within 72 hours:

- ❑ For patients in the acute phase of their stroke, the AlphaFIM® assessment should be completed on or by Day 3. For patients in the inpatient rehabilitation phase of their stroke, the FIM® assessment, should be completed within **72 hours of admission** AND again at **discharge**. OT, PT, SLP and Nursing are typically involved in completing the AlphaFIM® or FIM®.

FIM Instrument Overview.pdf

C. General Principles for Best Practice in Stroke Care

Mood and Emotion Post-Stroke
❑ All patients should be screened for depression with a validated tool, and should include screening for risk factors. Recommended tools include the PHQ-9, HADS, GDS or BDI. Patients identified as being at risk should be referred to a health care professional with expertise in diagnosis and management of depression. ❑ It is important to provide psycho-education surrounding post-stroke depression to patients and families and for a patient's mental health to be monitored throughout the continuum of stroke care.

Support, Education and Self-Management
❑ Support should be initiated from the onset of stroke and continue throughout all transitions and stages of care. This can include family counselling focused on psychosocial and emotional issues and role adjustment should be encouraged and made available to patients and their family members. ❑ Education and enabling self-management for people with stroke, their families and caregivers, should be included as part of all healthcare encounters, and during transitions. Education provided by staff should be documented.
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

D. Discharge planning

- ❑ Discharge planning should include the interprofessional team, the patient and caregiver/family
- ❑ Deliver timely and comprehensive information, education and skills training to all patients and their family and/or caregivers.
- ❑ Does patient meet the eligibility criteria for inpatient rehabilitation or post-hospital rehabilitation services?

Inpatient Rehabilitation	**Post-Hospital Rehabilitation services** **Programs accepting applications during COVID-19 are mostly available through virtual care.*
• Would benefit from interdisciplinary rehabilitation assessment and treatment from staff with stroke expertise • Goals for rehabilitation can be established • Medical stability • The patient demonstrates the ability to participate in rehab • Care needs cannot otherwise be met in the community	• Patient has functional goals that individual/intensive therapy • Medical stability • Patient can manage safely in-home environment with or without HCC • Patient has family supports • Primary rehabilitative needs can mostly be met in the community within a virtual care model of care with or without the assistance of a caregiver.

- **YES?**
  - liaise with stroke team to make referral to appropriate inpatient, outpatient or community rehab program (see table below).
  - Obtain consent from patient or substitute decision maker.
  - Provide education regarding the rehab application and the applicant process.

- **NO?**
  - Continue to monitor and assess rehabilitation needs
  - collaborate with the patient, family, caregiver and the interprofessional team to determine an appropriate discharge plan and link to appropriate community resources (e.g. CNIB, March of Dimes Canada, etc.).
  - Consider a family meeting for discharge planning.

<table>
<tr><th colspan="5">Inpatient, Outpatient and Community Rehab programs in the SW and ESC</th></tr>
<tr><th colspan="5">Inpatient Stroke Rehabilitation Programs</th></tr>
<tr><td>Parkwood Institute, London</td><td colspan="2">Woodstock General Hospital</td><td colspan="2">St-Thomas Elgin General Hospital</td></tr>
<tr><td>Huron Perth–
temporarily located in Seaforth</td><td colspan="2">Grey Bruce – Owen Sound Hospital</td><td colspan="2" rowspan="2">Hotel Dieu Grace Healthcare, Windsor</td></tr>
<tr><td>Bluewater Health, Sarnia</td><td colspan="2">Chatham Kent Health Alliance-Chatham Campus</td></tr>
<tr><th colspan="5">Outpatient Programs</th></tr>
<tr><td colspan="2">Comprehensive Outpatient Rehabilitation Program – Parkwood Institute, London
***Services provided virtually; in-person visits by exception*</td><td colspan="3">Intensive Rehabilitation Outpatient Program – Woodstock
**referrals accepted internally only at this time*
***Services provided face to face or/and via phone*</td></tr>
<tr><td colspan="2">Transitional Stroke Program – Chatham
**referrals not accepted at this time*</td><td colspan="2">Community Reintegration Program – Sarnia
**services provided virtually*</td><td>Windsor Outpatient Program - Hotel Dieu Grace, Windsor</td></tr>
<tr><th colspan="5">Community Rehabilitation Programs</th></tr>
<tr><td colspan="2">Community Stroke Rehabilitation Team (London, Middlesex, Elgin & Oxford; Grey Bruce; Huron Perth)
***Services provided virtually; in-person visits by exception*</td><td colspan="2">Community Outreach Team, Hotel Dieu Grace Healthcare, Windsor
**services provided virtually*</td><td>eRehab program (Windsor and Chatham)
**services provided in person and virtually*</td></tr>
</table>

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E. Patient & Family Information & Education

Education and Information is the responsibility of the entire health care team.
Ensure that you are keeping the patient, and their family members/caregivers apprised of all aspects of care and are providing any necessary education.
Education starts in the ER and continues throughout the inpatient phase into the community.

1. SW Stroke Assessment Checklist (see below)
2. Education & Community Resources
    - Guide for Stroke Recovery
    - Stroke Resources on the Southwest Healthline and Erie St Clair Health Line
    - Staff should be aware of methods to support communication with persons impacted by aphasia and other communication disorders. See Supported Conversation for Adults with Aphasia (SCA™) training module
    - CorHealth Clinical Tools and Resources
    - Supporting Stroke Survivors in Community Re-engagement Trigger Tool

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- Is the patient medically stable?
- Are their comorbidities, complications and/ or outstanding/pending medical procedures
- Are there any parameters you need to be aware of (e.g. BP, oxygen saturation, HR etc.)
- Code status
- Collaborate with and/or review interprofessional team members' notes (swallowing status, communication deficits transfers, behaviour etc.)

Initial and Ongoing Assessments		
Identify and prioritize potential referrals		
☐ ALC/same day discharges	☐ Lives alone	☐ Concerns from patient or family regarding ability to return home
☐ No fixed address	☐ Unidentified patient	☐ Next of kin identification
☐ Unable to return to work	☐ Medication compliance	☐ Other
Psychosocial Assessment		
☐ Current living environment	☐ Family/Community supports	☐ Current equipment
☐ Power of Attorney	☐ Family doctor	☐ Medication management
☐ Finances	☐ Mood Psychosocial concerns	☐ Education/Employment
☐ Recent stressors	☐ Emotional adjustments	☐ Other

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