# NZ Organised Stroke Rehabilitation Service Specifications (in-patient and community)

## Prepared by the National Stroke Network to outline minimum and strongly recommended standards for DHBs.

## Developed: December 2014 (updated May 2017)

It is expected that early or immediate rehabilitation in the acute phase of stroke is offered by the acute stroke team in an acute stroke unit (or under the umbrella of an acute organised stroke service). Please see separate specifications for this acute phase of stroke.

These service specifications refer to rehabilitation offered outside of the context of acute care and extend from the hospital into the community.

### 1. OVERALL *MINIMUM* REQUIREMENTS FOR STROKE REHABILITATION (in-patient and/or community)

### 1.1 Members of the stroke rehabilitation team

- Rehabilitation Physician and/or Geriatrician*
- Nurse*
- Physiotherapist**
- Occupational Therapist**
- Speech and language Therapist**
- Social Worker

Clinicians that add significant value to stroke rehabilitation, but are not mandated members of the stroke rehabilitation team currently:

- Dietitian
- Clinical Psychologist
- Pharmacist
- Service Co-ordinator/NASC
- Therapy/Rehabilitation Assistants

* Each centre should have a designated *lead* stroke rehabilitation physician or stroke rehabilitation geriatrician and *lead* stroke rehabilitation nurse.
** Each centre should have a designated *lead* stroke rehabilitation allied health professional. However, for daily clinical activities several clinicians can share patient responsibilities on a rotating basis.

**1.2 Staff education**

- Baseline qualifications yet to be defined
- Ongoing education should include a *minimum* of **eight** hours of formal stroke education annually for each designated stroke rehabilitation team member.

**1.3 Offer key components of stroke rehabilitation utilising written guidelines including:**

- Setting of functional goals and a process for regular evaluation of progress towards these
- Progress meetings
- Patient and family/whānau education
- Measurement of functional status on admission to and at discharge from the service. Functional status might also be formally assessed at intervals during the inpatient episode.

**1.4 Collaboration with acute stroke services (if not a comprehensive unit), Stroke Foundation, acute hospital services**

**1.5 Quality Assurance and Audit**

- All serious adverse events should be fully investigated and discussed as a team
- Regular stroke rehabilitation relevant audits
- A stroke rehabilitation registry is highly desirable.

**1.6 Research**

- There should be some evidence that the service engages in stroke rehabilitation research or external stroke audits.

**1.7 Staffing Levels**

There is a full range of team members (medical, nursing, allied health and support staff) with an appropriate skill base and training to provide comprehensive, contemporary programmes of care to address the impairments, activity limitations and participation restrictions present in the patients admitted to the stroke rehabilitation service. There are sufficient team member hours available to allow each patient to receive an individualised nursing and allied health programme of adequate intensity to meet their needs, delivered in a way that optimises the effectiveness and efficiency of the stroke rehabilitation programme.

As a guide in-patient staffing levels should be sufficient to enable care of patients and rehabilitation intensity in accordance with NZ Stroke Guidelines as a minimum. Community and early supported discharge teams should have sufficient staffing to allow the provision of ongoing rehabilitation as specified in the relevant section below without delay. All designated members of the stroke rehabilitation team should have some dedicated time (part or fulltime depending on patient volumes) specifically allocated to stroke rehabilitation and maintenance of stroke rehabilitation competencies.

## 2. IN-PATIENT STROKE REHABILITATION

### 2.1 Geographical area

Hospitals designated as providing an 'Organised Stroke Rehabilitation Service' should have a designated geographical area with stroke patients spending the majority of their rehabilitation stay in this 'unit'. This may be a comprehensive stroke unit or a stroke rehabilitation unit. Ideally beds are dedicated to stroke patients, but this is not mandatory. In small hospitals where a dedicated 'unit' may not be feasible due to low patient volumes patients may be admitted to a single general rehabilitation ward if all other components of organised stroke rehabilitation services are provided. Alternatively, if organised stroke rehabilitation services are not available patients should be offered a transfer to a more specialised centre using a defined and agreed pathway. Formalised remote support from a larger service may in some instances be a further option.

### *2.2* ***Minimum*** **requirements for in-patient stroke rehabilitation:**

- Co-located all ages adult stroke rehabilitation beds within a single general rehabilitation ward
- Interdisciplinary rehabilitation team with access to regular staff education and professional development specific to stroke
- At least **one** hour per working day of physical therapy (physiotherapy or occupational therapy) for goal related activities
- An environment and culture that supports activity over the 24 hour period which facilitates and reinforces therapy goals
- Written protocols for the assessment and management of common problems related to stroke, including as a *minimum* shoulder pain, continence, mood, falls, pressure injuries, dysphagia, nutrition and aphasia
- An interdisciplinary rehabilitation team meeting at least weekly with stroke specific rehabilitation needs and goals addressed
- Stroke education and information is readily available to those with stroke and their carers
- Documented goal specific rehabilitation plans for each patient that are developed in conjunction with the patient and their family
- Access to social work, dietetics, psychology and NASC as required.

### 2.3 Strongly recommended for in-patient stroke rehabilitation

- Dedicated and co-located all ages adult stroke rehabilitation beds on a single ward (comprehensive stroke unit or stroke rehabilitation ward)
- Dedicated specialised interdisciplinary stroke (or neuro-rehabilitation) team with access to regular staff education and professional development specific to stroke
- At least **one** hour of physical therapy and at least **45** minutes of every other required therapy discipline per day for goal-related activities.

## 3. COMMUNITY STROKE REHABILITATION

Community stroke rehabilitation includes access to rehabilitation in the home environment, outpatient services and the community of the person with stroke. All stroke patients should have access to community rehabilitation which is not limited by age.

Return-to-work issues (where relevant) should be identified as soon as possible after the person's stroke, reviewed regularly and managed actively by the community team.

### *3.1* *Minimum* requirements for community stroke rehabilitation

- An interdisciplinary community rehabilitation team with stroke specific skills, who support people with stroke to transition seamlessly into the community
- The team includes the following members:
    - Nurse specialist or speciality nurse
    - Allied health professionals (including PT, OT, SLT and social work) with expertise in stroke
    - Medical practitioner with expertise in stroke medicine
    - Access to, dietetics, psychology and NASC as required
- Team members have access to stroke specific training (minimum 8 hrs / year)
- A single point of entry for referrals for all adult stroke service users and health professionals
- Work in partnership with the patient and family/Whānau to enhance autonomy and self-management, with use of 'homework' to increase intensity of practice and activity levels
- Documented goal specific rehabilitation plans for each patient that are developed in conjunction with the patient and their family
- Ability to deliver up to three sessions per week of Physiotherapy, Occupational Therapy or Speech Language Therapy as needed in the first four weeks of the community rehabilitation* programme to work towards patient/family/whānau goals. Sessions may be delegated to trained therapy/rehabilitation assistants as appropriate
- A weekly interdisciplinary team meeting
- Strong links between the in-patient rehabilitation team and the community team to assist with discharge planning and to discuss long term goals for the patient's rehabilitation once they are in a community setting
- Established processes for communicating effectively with GPs, other primary care providers and the Stroke Foundation and options for ongoing rehabilitation in the community.

* *Sessions can be held in individuals own home, outpatient setting or other community setting depending on the individual's needs.*

### 3.2 Strongly recommended for community stroke rehabilitation:

- A specialised interdisciplinary team with highly developed stroke specific skills
- That staff from community stroke services attend interdisciplinary team meetings on the hospital stroke units to assist with discharge planning and to discuss long term goals for the patients' rehabilitation once they are in a community setting.

## 4. EARLY SUPPORTED DISCHARGE SERVICES (ESD)

ESD is distinct from community rehabilitation due to the intensity and specificity of the service. It is recommended that DHB s ensure they have responsive and well developed community stroke rehabilitation teams prior to implementing ESD.

An ESD services supports patients to leave hospital 'early' and return home for treatment before the end of the expected length of stay. ESD commences within the first 21 days post-stroke. ESD is suitable for selected patients who do not need medical intervention and do not have high nursing needs (e.g. naso-gastric feed).

Most ESD teams are made up of Physiotherapists, Occupational Therapists, Speech Language Therapists, Nurses, Social Workers and Rehabilitation/Therapy assistants. They need access to medical, dietetics, psychology and NASC as required.

### 4.1 Requirements for ESD

- Provision of intense rehabilitation in the community with the same frequency as inpatient services if it is used an alternative to in-patient rehabilitation. Treatment intensity should meet patient need
- Contact and supports in place within 24 hours of discharge and assessment and treatment within **three** days
- A specialised interdisciplinary stroke (or neuro-rehabilitation) team with access to staff education and professional development specific to stroke
- A single point of entry for all stroke service users and health and professionals
- A weekly ESD interdisciplinary team meeting
- Ability to pick up patients and start treatment rapidly
- Flexibility to adapt to fluctuating patient numbers
- ESD therapists need to be supported by trained rehabilitation support workers to enable people with stroke to carry over rehabilitation techniques into activities of daily living
- To be able to treat people with stroke **seven** days a week as clinically appropriate
- To in-reach to acute services
- To provide access to dietetics and psychology services as required
- To provide rapid access to medical consultation as required
- Documented, goal specific, rehabilitation plan for each patient developed in conjunction with the patient and their family.