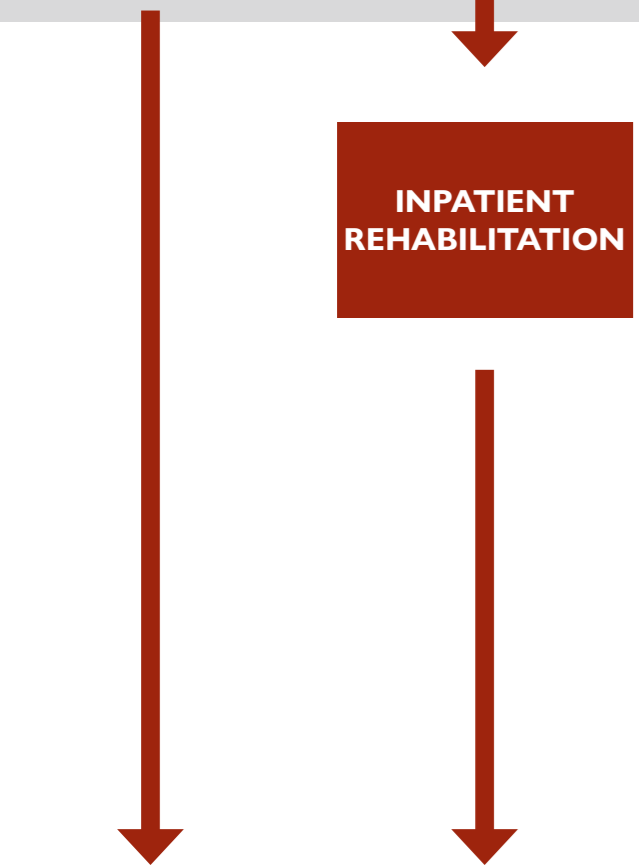


TRANSITIONS IN STROKE REHABILITATION

This document highlights the needs and experiences of people with stroke & family/whānau. It makes suggestions & recommendations for services and health professionals to support optimal transitions of care.

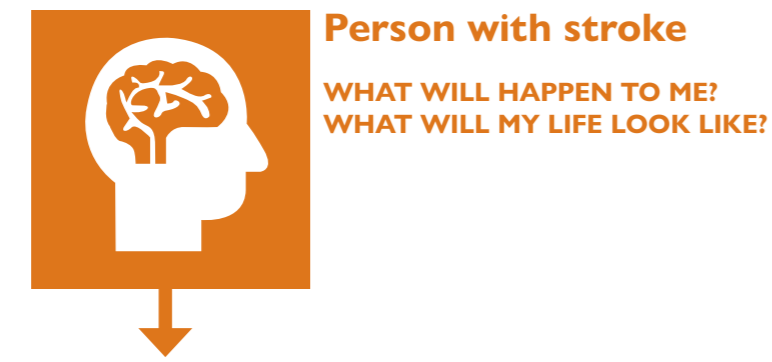


ACUTE STROKE



EARLY SUPPORTED DISCHARGE **COMMUNITY HOME BASED REHAB**

LIVING WITH STROKE
(Goals and outcomes that matter to people with stroke)



• Feeling shock, grief, fear, uncertainty, hope for normality, early response to loss

• Realising impacts of stroke – financial, emotional, functional etc
• Worrying about the future and what it might look like. Hope and uncertainty
• Seeking confidence / support to do more
• Focusing on regaining function and getting home
• What I need to do and what I want to do

• Readjusting
• Confronted by challenges (eg fatigue) and realising how things are different
• Growing insight into impact of stroke
• Want to be home but often feel unprepared for home
• Experiencing changes in identity, roles, relationships and routines. At risk of isolation
• Holding more responsibility for recovery and rehabilitation

• Having hope for the future
• Valuing social connections (including people with similar experiences)
• Engaging in valued leisure / work activities. Growing confidence, control & self management. Being healthy, active and accepted
• Able to access services (eg driving, Return To Work)
• Having sense of security about the future. Feeling valued, involved in society



• Feeling shock, grief, fear, loss, uncertainty, hope for normality

• Preparing for discharge and what it will bring about
• Experiencing new and changed roles
• Concerns about the future
• Uncertainty about what will happen
• Sense of 'ambiguous loss' for the person and relationship that existed pre-stroke
• Confidence to allow person with stroke to do more
• Making space to attend to their own wellbeing and relationships
• Financial worries

• Responsibility is 24/7
• Experiencing changes in identity, roles, relationships and routines
• Often feel unprepared for coming home
• Managing strangers in the home & co-ordinating care
• Managing respite care
• At risk of fatigue and isolation
• May feel excluded from rehabilitation
• Sense of 'ambiguous loss' for the person and relationship that existed pre-stroke
• Growing confidence to allow person with stroke to do more
• Relationships altered
• Making space to attend to their own wellbeing and relationships

• Having ongoing supports
• Able to engage in valued activities
• Sense of independence
• Long term impact and adjustment
• Sense of security about the future



• Get to know the person and their family – who they are, what matters to them
• Aim for kind, clear consistent communication about their condition, progress and future
• Recognise the affect stroke is having on them
• Ensure cultural awareness & safety

• Identify and focus on outcomes that matter to the patient/family/whānau
• Provide skilled, evidence-based, person-centred care at the appropriate intensity
• Consider psychosocial wellbeing. Proactively share knowledge about recovery and life after stroke so people know what to expect
• Support patients toward independent decision making including well-judged risk-taking & self-management
• Involve patient & family in rehab discharge planning. Provide education & strategies to support self-management & to equip people to live well after discharge
• Trial home visits
• Offer training & opportunities for practice (in natural contexts)
• Connect with support services & home-based rehab providers
• Transitions of care plans that include patient/family priorities, strengths, potential, details of ongoing rehab & support providers
• Incorporate a whānau ora approach

• Negotiate rehab timetables and rehabilitation plans
• Work as a team, linking in other providers and services as required
• Include family and support people in rehab planning and treatment, recognising carers as critical partners in care. Consider needs of carers
• Review hopes, priorities and goals and match rehab to these, considering people's holistic needs. Plan for next steps and life after formal rehab
• Help people understand what to expect
• Connect with support services. Transitions of care plans include patient/family priorities, strengths, potential, & options/details for ongoing supports
• Consider cultural beliefs & seek expertise to support transition/discharge procedures

• Information about supports (including peer supports)
• Ongoing access to specialist supports for areas still required e.g. driving, Return To Work, psychosocial cultural supports
• Clear communication / handover between tertiary / primary health services (e.g. GP)



• Timely transitions between services (settings and providers)
• Clear information flow between services. Care pathways
• Clear communication and resources to help people understand recovery & services

• Resource services to enable staff to provide appropriate intensity in fit-for-purpose facilities
• Ensure the rehabilitation environment fosters participation & recovery over 24 hours
• A skilled comprehensive team with connections to acute & community-based teams that can support people's psychosocial and cultural needs
• Processes and protocols to support efficient & inclusive rehab discharge planning
• Regular audits to monitor & improve service quality
• Quality processes that include opportunity for patient / family feedback
• Professional development for staff
• Enable flexible services (with choice) individually adjustable in keeping with need
• Ensure services are culturally safe, appropriate & have access to cultural expertise

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• People with stroke / caregivers / primary care providers are able to access rehab services and specialist review as required
• Rehabilitation services can be reactivated in response to patient goals, needs, and changes in function
• Information and connections with community cultural resources and groups