Acknowledgements

We would like to offer sincere thanks to the many contributors whose commitment and knowledge have informed the development of the Stroke Rehabilitation Pathway and Decision Support Tool. We would like to thank the Statewide Stroke Clinical Network Steering Committee members for their on-going commitment, expertise and comment throughout the development of the paper.

We would also like to thank the members of the Stroke Rehabilitation Work Group, Chaired by Associate Professor Susan Hillier, for their dedication, information and feedback, particularly to those who consistently attending meetings. They are; Peter Anastassiadis, Peter Bastian, Maria Crotty, Michelle Curtis, Robyn Dangerfield, Caroline Fryer, Peter Hallett, Tony Hewitt, Catherine Lieu, Shelley Lush, Elizabeth Lynch, Jo Murray, Annette McGrath, Antonia McGrath, Cathy Young, and Girolamo (Roly) Vinci.

Disclaimer

This pathway has been developed by the Statewide Stroke Clinical Network. There has been investment in Rehabilitation Services across South Australia and this pathway is intended to be used to support service change and best practice within the funds that have been allocated. The pathway is expected to challenge how any current funds for stroke rehabilitation are spent ensuring that the allocated funds are reviewed and used to deliver this best practice pathway. The pathway is not a tool to seek funds over and above what is allocated now or into the future for these services.
# Table of Contents

Acknowledgements ................................................................. 2

Introduction ............................................................................ 4

The Pathway ............................................................................ 4

Home and Inpatient Pathway .................................................... 7
Introduction

Establishment of rehabilitation services has been identified by the Rehabilitation Clinical Network as a high priority – particularly for people living in Northern Adelaide. Stroke survivors form a large client group for rehabilitation.

The National Stroke Foundation have developed *Clinical Guidelines for Stroke Management 2010* (Guidelines) as a resource for providing best practice care to people with stroke from hyper-acute care, through rehabilitation and long term community living.

The Statewide Stroke Clinical Network Steering Committee appointed Associate Professor Susan Hillier to chair a workgroup to develop a stroke rehabilitation pathway, based on the Guidelines, to enable consistent best practice stroke rehabilitation care across South Australia. The following pathways are the result of this work. The Stroke Clinical Network recommends this pathway be incorporated into stroke rehabilitation care to provide good patient outcomes.

The Pathway
Person with stroke (PWS) receives acute stroke care, including rehabilitation from day one (refer to Acute Stroke Unit Protocols) until their acute phase is passed.

PWS assessed in the CSU to receive rehabilitation unless he/she meet the exception rules.

The default is that all PWS should receive rehabilitation unless the exceptions apply. This is based on the literature that confirms there is evidence that all can benefit from rehabilitation and there is no evidence that particular groups do NOT benefit from rehabilitation.

The decision for the model of care for rehabilitation is driven by:
- client preference and need, i.e. ability to function in their own versus an alternate environment, as well as
- expert opinion and
- best available evidence.

The model provides flexibility and is inclusive. Decision making about where rehabilitation occurs is based on the Decision Making Tool for Rehabilitation. This requires analysis of where the identified needs are best met for the various domains. The evidence supports that early supported discharge home is preferable if possible.

The Decision making tool becomes the Rehabilitation plan and forms the basis for all subsequent reviews.

The aim for discharge (transition) is for the PWS to return home either directly from the CSU as early supported discharge OR via an inpatient unit.

Access to rehabilitation either at home or as a day/out patient is available to all patients as appropriate.

Home may be a residential aged care facility and if there is no access to rehabilitation or resources in aged care facility, then they may access other options as described.

PWS receives (multi-disciplinary) rehabilitation in their home, with flexibility to be able to access day patient or out patient services in a hybrid model. This option is preferred based on the evidence.

PWS is able to attend (day) hospital or clinic rehabilitation services as a day patient or an out patient. Transport options are available should they be required.

The PWS is assessed as requiring inpatient care using the Decision Making tool for Rehabilitation. The PWS is transferred to a specialist rehabilitation centre where they receive care and regular assessments with the view to going home.

1. Return to pre-morbid function: PWS has made a ‘full’ recovery in all aspects, such as functional (physical, communication etc), emotional/psychological and cognitive
2. Palliation: Death is imminent, refer to palliative care team.
3. Coma and/or unresponsive, not simply drowsy
4. Declined rehabilitation

All exceptions feed into monitoring/surveillance and re-entry so they can receive
Monitoring, Surveillance and re-entry

All PWS have the ability to re-access any rehabilitation services at any time during their ongoing recovery or long-term care. The overall aim is to promote/maintain the best level of function in all domains.

**Principles to drive processes**
- Focus on PWS and their supports
- Available and accessible
- Maintain relationship with expert team
- Link with NSF registry
- All information travels with PWS/family as well as maintained at the facility they attend. This includes discharge/transition summaries. This may also be held at a web-based system in future.
- Self-referral is available (via central number for appointment with closest facility/team)

**Two functions of monitoring, surveillance and re-entry**
1. Monitor status/needs for change and update plan/pathway;
   - Improving $\rightarrow$ continue
   - Static – follow most appropriate path – continue or re-enter
   - Declining $\rightarrow$ re-enter pathway

**Two tiers of monitoring:**
1. Complex - requires access to all/part of MD team
2. Simple – single discipline review (e.g. GP)

**Process** is that review appointment is always scheduled at the completion of any stage in the pathway. The level of monitoring is also established as complex or simple at this time and the appointment made with the relevant staff. The staff then utilise the Decision Making Process to evaluate across all domains and flag status/need.

**Special need flags:**
- These flags are not exclusionary, but may indicate more intensive rehabilitation or referral to specialist areas, such as psychiatry or complex medical. Some flags may be:
  - Pre-morbid conditions
  - Non-compliance
  - Decreased pre-morbid function
  - Decreased social support
  - Incontinence (x2)
  - Decreased engagement
  - Conversion disorders
  - Decreased accommodation options
  - Co-morbidities
  - Apathy
Home and Inpatient Pathway

Yes, Rehabilitation

Inpatient Rehabilitation

Establish Team

Domain assessments

Goal setting

Management

Long-term management plan

Monitoring & Surveillance

Home Rehabilitation

Review cycle

Review cycle
Yes, Rehabilitation for all stroke patients.

All patients from the CSU are referred to receive rehabilitation unless they meet the exception rules.

The model of care for rehabilitation is driven by client preference and level of need, i.e. level of support/ability to function in their own environment. The model provides flexibility and is inclusive. Decision making about where rehabilitation occurs is based on the Decision Making tool for Rehabilitation.

<table>
<thead>
<tr>
<th>Establish team and key worker identified</th>
<th>Identifying the likely rehabilitation team. This includes the designation of a key worker as well as the possible/main disciplines as suggested by the needs analysis. The key worker model</th>
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<tr>
<td></td>
<td>allows for the family and PWS to have “one contact” for organisational or general inquiries or to direct their specific inquiries</td>
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<td>facilitate all aspects of the rehabilitation plan, ensure meetings etc are scheduled and occur within the necessary timeframes and with the salient people/processes</td>
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<td>remains a constant for the PWS and their family for the service duration</td>
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<td></td>
<td>has credibility/experience in stroke rehabilitation and can confidently guide the PWS and family through the process/es</td>
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<td>key worker roles spread across specialist team – alternate model may be one coordinator.</td>
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| Domain Assessment | This is performed by the identified personnel and will build on the initial needs analysis in the relevant domains. Every effort will be made to avoid duplication – this will require team communication and planning so that information required across personnel is only gathered once (e.g. demographics, FIM, stroke severity, home situation etc). It is anticipated that each discipline/personnel will also have specific assessments to inform the management plan/s. |

| Goal Setting | This process begins informally between the individual team members and the PWS/family as the assessment occurs. It may be facilitated by the PWS being given a “goals menu” to consider. Goals are documented and agreed to by all parties in a scheduled meeting between the PWS/family and the relevant team members. The emphasis will be on client-centred goals. Various models may be used including Goal Attainment Scaling; SMART goals etc. |

<table>
<thead>
<tr>
<th>Management</th>
<th>Based on the best available evidence and wherever possible following the NSF Guidelines for stroke rehabilitation. Key features for management are:</th>
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<td></td>
<td>&gt; Intensity – maximise engagement and opportunities for practice at all times – including weekends</td>
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<td>&gt; Carer training and education</td>
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<td>&gt; Stroke team has at least one senior/experienced stroke clinician for each core discipline (medical, nursing and each AH). These lead clinicians can mentor younger/less experienced team members.</td>
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<td>&gt; Access to specialty clinical areas for screening/support/intervention including: psychology; neuropsychology, dental, dietary/nutrition and neuro-opthalmology</td>
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</table>
- Access to complex interventions/management: spasticity management (BOTOX, splinting/casting); Driving clinic; Vocational rehabilitation; sexuality issues.
- Enabling environment - quiet rooms; physically accessible, appropriate communication strategies (taking into account cultural factors, language skills and literacy levels); assistive technology
- Rehabilitation is task specific – functionally orientated with opportunities for practice and feedback.
- Participate in AROC benchmarking, NSF auditing for accountability.
- Encourage and promote research – both initiating and participating in research that furthers stroke rehabilitation
- Establish network (requisite skills and knowledge) to enable long term planning / lifestyle approach
- Secondary prevention is on going – medical management as well as lifestyle approach with self-management

| Review Cycle | This is an ongoing cycle of review that occurs informally between the individual team members and the PWS, and occurs formally at case conferences between team members and at family meetings. Goals are reviewed and amended and if a transition point (e.g. discharge home) is imminent this is also planned for and action plans will result. |
| Monitoring, Surveillance and re-entry | All PWS have ability to re-access any rehabilitation services at any time during their ongoing recovery or long term care. See above for details. |
| Long term management plan | Involves various other agencies – community integration focus includes self-management. Refer to relevant working group within Australian Stroke Coalition. Still allows for rehabilitation monitoring/re-entry. |
| Lifestyle | |