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.

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Previous versions: - May 2017, December 2014

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. (Appendix 1)

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

1. *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 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
- Allied Health /Rehabilitation Assistants
- Cultural support worker (Maori / Pacifica /other)
- Spiritual support worker
- Exercise Physiologist

* Each DHB should have a designated *lead* stroke rehabilitation physician or stroke rehabilitation geriatrician and *lead* stroke rehabilitation nurse.
** Each DHB 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 Workforce

There is a full range of team members (medical, nursing, allied health and support staff) with an appropriate skill base and training. They 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 enough staff available to provide each patient with an individualised nursing and allied health programme of sufficient intensity to achieve their rehabilitation goals.

In-patient staffing should be sufficient to enable care of patients and provision of rehabilitation intensity in accordance with Australian / NZ Stroke Guidelines. Community and early supported discharge (ESD) teams should be staffed to provide rehabilitation as specified below. Stroke rehabilitation team members who provide other services should have some allocated time (part or fulltime depending on patient volumes) specifically for stroke rehabilitation.

1.3 Staff education

- Baseline qualifications - to be determined locally
- Ongoing education should include a *minimum* of **eight** hours of formal stroke education annually for each designated stroke rehabilitation team member
- Regular familiarisation with Australian/NZ Stroke Guidelines (https://informme.org.au/Guidelines/Clinical-Guidelines-for-Stroke-Management-2017)

1.4 Offer key components of stroke rehabilitation utilising written guidelines including:

- Setting of person / whanau centred goals and a process for regular evaluation of progress towards these
- Regular IDT progress meetings
- Patient and family/whānau information, advice and support
- Measurement of functional status on admission to and at discharge from the service (e.g. AROC FIM) Functional status might also be formally assessed at regular intervals during the inpatient stay.

1.5 Collaborative links with acute stroke services (if not a comprehensive unit), acute hospital services and Stroke Foundation.

1.6 Quality Assurance and Audit

- All serious adverse events should be reported, fully investigated and discussed as a team
- All stroke rehabilitation patients should be included in AROC data collection for inpatient and community stroke rehabilitation
- Participation in other regular stroke rehabilitation relevant audits
- Quarterly reporting of Ministry of Health indicators for stroke rehabilitation

1.7 Research

- The service engages in stroke rehabilitation research or external stroke audits.

2. IN-PATIENT STROKE REHABILITATION

2.1 Geographical area

Hospitals designated as providing an 'Organised Stroke Rehabilitation Service' should have a designated geographical space with stroke patients spending the majority of their rehabilitation stay in this area. This may be a comprehensive stroke unit or a stroke rehabilitation unit. In small hospitals where a dedicated 'area' may not be feasible due to low patient volumes, patients may be admitted to a single general rehabilitation ward where minimum components of inpatient stroke rehabilitation are met.
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 (e.g. telerehabilitation) 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 stroke specific staff education and professional development (minimum of 8 hours per year)
- Physical therapy (Physiotherapy and Occupational Therapy) and Speech Language Therapy should be provided in line with current Australian/NZ Stroke Clinical Guideline recommendations for therapy intensity
- Work in partnership with the patient and family/Whānau to enhance autonomy and self-management
- An environment and culture that promotes rehabilitation over the 24 hour period
- 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 vision
- An interdisciplinary rehabilitation team meeting (at least weekly) that addresses stroke specific rehabilitation needs and goals including discharge planning
- Stroke information, advice and support is offered to people with stroke and their carers (including in aphasia friendly formats)
- Documented goal specific rehabilitation plans for each patient that are developed with the patient and their family/whanau
- Access to social work, dietetics, clinical/neuro psychology, cultural and spiritual support workers 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 neurorehabilitation) team with access to regular staff education and professional development specific to stroke

3. EARLY SUPPORTED DISCHARGE SERVICES (ESD)

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

An ESD service supports patients to leave hospital 'earlier' and return home for rehabilitation.

ESD is appropriate for a selected group of stroke patients with mild to moderate (rather than severe) disability, who do not need hospital medical intervention and do not have high nursing needs (e.g. naso-gastric feed). Each team should have clear guidelines on which patients are suitable. ESD should be offered early, such as when the person with stroke can transfer from bed to chair independently or with assistance.

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

3.1 Requirements for ESD

This is inpatient rehabilitation in the home environment. Therefore, the following requirements apply:

- A clear process for identifying and selecting suitable patients for ESD
- Provision of rehabilitation in the community with similar elements and intensity as inpatient services
- Contact and home supports are in place within 24 hours of discharge and assessment
- A clear entry process for all stroke service users and referring health professionals
- A weekly ESD interdisciplinary team meeting
- Ability to pick up patients and start treatment rapidly
- Flexibility to adapt to fluctuating patient numbers
- A specialised interdisciplinary stroke team with access to staff education and professional development specific to stroke
- 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 support people with stroke **seven** days a week as clinically appropriate
- To in-reach to acute services
- To provide rapid access to medical consultation as required
- Ability to provide telerehabilitation options

  Documented, goal specific, rehabilitation plan for each patient developed in conjunction with the patient and their family/whānau.

4. 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.

4.1 ***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:
    - Specialist Nurse
    - Allied health professionals (including PT, OT, SLT and social work) with expertise in stroke
    - Medical practitioner with expertise in stroke
    - Allied Health/Rehabilitation assistants
    - Access to, dietetics, psychology, NASC and Stroke Foundation support services
- Team members have access to stroke specific training (minimum 8 hrs per year)
- A single point of entry process for referrals for all adult stroke service users and referring health professionals
- Work in partnership with the patient and family/whānau to enhance autonomy and self-management
- Documented goal specific rehabilitation plans for each patient that are developed 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. Sessions may be delegated to trained therapy /rehabilitation assistants as appropriate
- A weekly interdisciplinary team meeting
- Ability to provide telerehabilitation options
- Strong links between the in-patient rehabilitation team and the community team to enable seamless transitions
- Processes for communicating effectively with GPs, other primary care providers, the Stroke Foundation and other community rehabilitation providers.

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

4.2 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 enable seamless transition to the community.

Appendix 1 – Acute Stroke Service Specifications: https://strokenetwork.org.nz/guidelines-and-recommendations/service-specifications-for-dhbs?src=nav