Supporting Patients Across Transitions Home: The S-PATH program design and implementation

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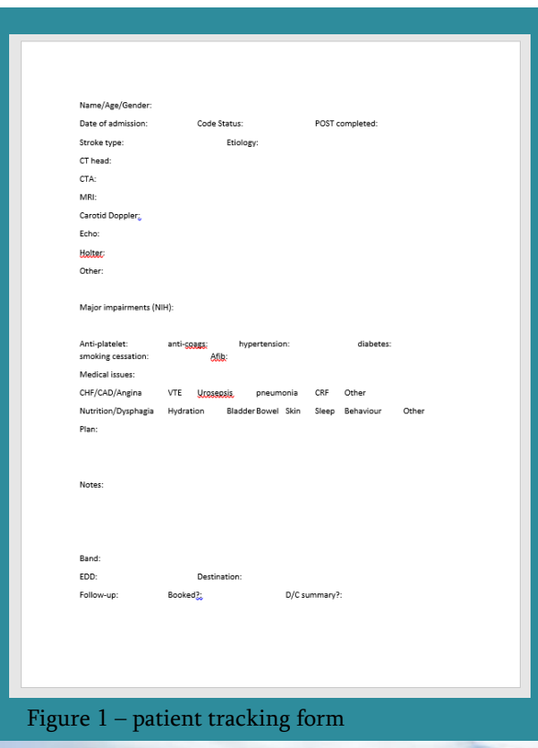
Background

Canadian Stroke Best Practices outlines key points in supporting patients through transitions. With decreasing lengths of stay in acute care settings it is important to ensure patients, families, staff and physicians receive appropriate follow up of testing, results, or treatment plans. Both the acute stroke team and the stroke rehabilitation team work together to provide seamless transitions to patients.

Purpose

For patients and families changes in their environment, MRP, allied and nursing staff and the speed at which these changes occur can be a challenge. It is important all information is transferred between care teams in order to insure appropriate management is timely. In order to provide appropriate medical support during the transition from acute care to rehabilitation or home, the stroke neurologist and Nurse Practitioner will follow-up with patients once they have been discharged from acute care. Follow up includes any outstanding test results. Insuring the patient and family have had any questions about their acute care stay answered. Ensuring appropriate follow up has been arranged.



Name/Age/Gender:
Date of admission: Code Status: POST completed:
Stroke type: Etiology:
CT head:
CTA:
MRI:
Carotid Doppler:
Echo:
Holter:
Other:

Major impairments (NIH):

Anti-platelet: anti-coags: hypertension: diabetes:
smoking cessation: Afib:
Medical issues:
CHF/CAD/Angina VTE Urosepsis pneumonia CRF Other
Nutrition/Dysphagia Hydration Bladder Bowel Skin Sleep Behaviour Other
Plan:

Notes:

Band:
EDD: Destination:
Follow-up: Booked? D/C summary?:

Figure 1 – patient tracking form

Methods

Implementation and planning was divided into two streams; either discharge home or transfer to rehabilitation.

Discharge Home:

1. Every patient gets the contact information of the Nurse Practitioner prior to leaving hospital
2. Discharge report run weekly to identify patients
3. Book appointment 2 weeks post discharge
4. Chart review – outstanding diagnostics completed, discharge summary, Stroke Clinic follow up booked
5. Complete call, document, follow-up any outstanding issues

Transfer to Rehabilitation:

1. Discharge report run weekly to identified transferred patients
2. Daily rounding to identify outstanding issues requiring follow up
3. Use of patient tracking form to track any follow up needed
4. Visit patient within first week post transfer or for specifically timed follow up diagnostics

Key Findings

There was no process by which discharge patients are identified and sorted by destination.

Project began as a manual audit of patients leaving the in-patient unit.

Using available discharge reports did not provide required information about disposition.

Developed the process of identifying patients, and sorting them to either telephone follow-up or visit on the rehabilitation unit.

Developed standard work around making and registering patients in follow up clinic.

Originally thought process of follow up to rehabilitation would be initiated first, once project began the follow up home process came online first. The process for discharge home required input from IT support. In order to measure visits and outcomes a telephone clinic was set up. Any patient that goes home from their acute hospital stay is booked for a telephone appointment approximately 2 weeks post-discharge.

"a calmness in the storm" – patient feedback

Discussion

After implementation feedback has been very positive. Follow up telephone themes include discussion regarding: back to work, resuming driving, diagnostic tests results, paperwork completion, confirmation of follow up appointments, medication adherence. This process has identified cancelled (but required) diagnostic testing, avoided an Emergency Department visit for a possible drug reaction, multiple missed Stroke Clinic appointments and given patients an opportunity to ask any discharge related questions in a timely manner.

The follow up to rehabilitation has allowed patients to start their rehabilitation program as soon as possible, removing the barrier of incomplete diagnostics. Allows for a process by which the Physiatrists can confirm and continue the treatment recommendations from the Stroke Neurologists.

Many patients have voiced their appreciation for having access to the acute stroke team in order to support their transition home.

References

1. Cameron et al. (2016) Canadian Stroke Best Practice Recommendations: Managing transitions of care following stroke, guidelines update 2016. International Journal of Stroke 2016. 11(7) 807-822
2. Nurse Practitioner Practice Standard. College of Nurses of Ontario. Revised 2018

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