Community Standards of Care	The Central East Stroke Network's Standards of Care provide an overview of key stroke best practices and highlight how these practices have been implemented while supporting regional priorities. Completing the self-assessment will allow your team to determine the current state of stroke care at your organization. Teams can then utilize the self-assessment results to develop quality improvement plans to be implemented over the coming year.			
Instructions for Completion of the Standards of Care Self-Assessment Organizational lead is to complete the self-assessment of standards of care in collaboration with interprofessional teams by: • selecting the most appropriate response in column E: Current State (N, NI, P, C) (notes: see cell E2 for definitions; items that are N.A. (not applicable) have been pre-populated) • entering any notes/comments that may be helpful in column F. If you require any assistance or have any questions please contact the Central East Stroke Network - sooleyd@rvh.on.ca **Once completed,** return this document to the Central East Stroke Network - cornerl@rvh.on.ca		Resource links that are important to address this standard.	**N** = Standard not implemented. QI not initiated. **NI** = Standard not implemented. QI plan to address standard in development. **P** = Standard partially implemented. QI plan to address standard in progress. **C** = Complete. Standard fully implemented and sustained.	This column is for your use. Add any notes, comments, etc. that are helpful for your organization.
Theme / Area of Focus	**Type**	**Resource Links**	**Current State** (select based on criteria outlined above)	**Notes**
1.0 System of Access for Stroke Care: Collaboration and coordination across service providers to facilitate access to primary care, rehabilitation and community supports to get the right patient, to the right place, at the right time.				
Referral protocols support timely access to **regular stream** in-home community-based stroke rehabilitation within 48 hours of discharge from acute or 72 hours of discharge from inpatient rehab	Protocol/Process	See page 92 https://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_stroke.pdf https://www.strokebestpractices.ca/recommendations/stroke-rehabilitation/outpatient-and-community-based-stroke-rehabilitation-including-esd		
In-home **regular stream** stroke rehabilitation programs ensure: • 2 to 3 visits per required discipline (for OT, PT, and S-LP) per week • 45 minutes of therapy per day per discipline • a duration of 8-12 weeks, based on patient need	Protocol/Process			
Referral protocols support timely access to **Early Supported Discharge stream** of in-home community-based stroke rehabilitation within 48 hours of discharge from acute or 72 hours of discharge from inpatient rehab	Protocol/Process	https://cesnstroke.ca/wp-content/uploads/2021/06/CESN-Rehab-Newsletter-Issue-3-March-2017-final.pdf https://www.corhealthontario.ca/resources-for-healthcare-planners-&-providers/stroke-general/piwp/esd See page 87 https://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_stroke.pdf https://www.strokebestpractices.ca/recommendations/stroke-rehabilitation/outpatient-and-community-based-stroke-rehabilitation-including-esd		
In-home **Early Supported Discharge stream** stroke rehabilitation programs ensure: • a minimum of 5 days/week of therapy • access to OT, PT, S-LP at a minimum • similar intensity of therapy per day as Inpatient rehab (3 hours/day shared between required disciplines) • a duration of approximately 4 – 5 weeks, based on patient need	Protocol/Process			

Theme / Area of Focus	Type	Resource Links	Current State (select based on criteria outlined above)	Notes
Process to facilitate access to hospital-based inpatient and outpatient stroke rehabilitation as necessary	Protocol/Process			
Process to identify when follow-up with physician is required to address need for primary or secondary stroke prevention services	Protocol/Process			
Models of virtual care, including technology such as telemedicine, regular telephone follow-up, and web-based support, are utilized to increase access to under-serviced areas as appropriate	Transition Support	See Virtual Care Resources https://www.heartandstroke.ca/what-we-do/for-professionals Scroll down to Virtual Care https://cesnstroke.ca/clinical-resources-tools/		
Program participates in development of a coordinated care plan between community service providers, primary care provider and the hospital/facility, if appropriate	Transition Support			
Communication strategies facilitate the sharing of all information concerning the patient, including assessments, treatment plans, rehabilitation goals and progress, between healthcare providers and settings	Standardized Communication			
Staff ensure supported transitions and warm handoffs to support integrated stroke care	Transition Support	https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html		
Service providers have the means to search online databases, such as thehealthline.ca, and know where to find information regarding community services and resources	Transition Support	https://www.thehealthline.ca/		
Program utilizes the Canadian Stroke Best Practice Recommendations for Stroke Care, Transitions of Care Checklist to ensure the transition needs of patients/families are met	Transition Support	https://www.heartandstroke.ca/-/media/1-stroke-best-practices/transition-of-care-nov2019/csbpr-transitions-box1-18nov19-final.ashx?rev=e7205dc183a548278bd88109c05cbe80		
2.0 Early Assessment & Management: Timely access to community-based assessment, management, prevention of secondary complications, and secondary prevention for TIA, minor stroke (non-disabling) and suspected acute stroke, to achieve best patient outcomes, based on the Canadian Stroke Best Practice Recommendations (CSBPR).				
Interprofessional team uses standardized, validated assessment tools	Protocol/Process	See "Clinical Topics" - "Assessments & Screening" - "Suggested Screening and Assessment Tools from Canadian Stroke Best Practice Recommendations" https://cesnstroke.ca/clinical-resources-tools/ Stroke Engine - Stroke Assessments A-Z https://strokengine.ca/en/assessments/		
Interprofessional team assess patient and family/caregiver knowledge, self-management capability, learning needs, and readiness for information	Protocol/Process	http://www.teachbacktraining.org/home https://www.swselfmanagement.ca/smtoolkit/ **Self Management Programs** NSM https://www.nsmselfmanagement.ca/ Central https://healthy-living-now.ca/ Central East https://www.ceselfmanagement.ca/		

Theme / Area of Focus	Type	Resource Links	Current State (select based on criteria outlined above)	Notes
Medication reconciliation protocol	Protocol/Process			
Interprofessional team screen/assess and manage:				
Visual perceptual	Protocol/Process	https://cesnstroke.ca/clinical-resources-tools/		
Central post-stroke pain	Protocol/Process			
Communication	Protocol/Process			
Cognition	Protocol/Process			
Depression	Protocol/Process			
Dysphagia	Protocol/Process			
Malnutrition and Dehydration	Protocol/Process			
Hemiplegic shoulder pain and complex regional pain syndrome	Protocol/Process			
Lower extremity	Protocol/Process			
Mobility	Protocol/Process			
Psychosocial needs of patients and families/caregivers	Protocol/Process			
Secondary complications post stroke that may arise including continence issues, aspiration pneumonia, etc.	Protocol/Process			
Upper extremity	Protocol/Process			
Advanced care plans are reassessed periodically, and updated if needed, such as when there is a change in health status	Protocol/Process	www.advancecareplanning.ca		
Processes that support referral and liaison with a team experienced in providing end-of-life care for stroke patients as appropriate based on person's goals of care and condition	Protocol/Process	scroll down to "Palliative Care & Advance Care Planning" section https://cesnstroke.ca/clinical-resources-tools/		
Continence management protocol	Protocol/Process	https://cesnstroke.ca/clinical-resources-tools/		
Skin health and wound care protocol	Protocol/Process			
Process to ensure that persons with stroke are periodically screened for post-stroke fatigue	Protocol/Process			
Process to ensure that people who experience post-stroke fatigue are screened for common and treatable post-stroke co-morbidities or medications (mood, sleep disorders, pain, systemic infection such as urinary tract infections, dehydration, hypothyroidism, sedating drugs)	Protocol/Process			
Process to access screening and management of lifestyle and vascular risk factor management and co-morbidities such as blood pressure, cholesterol and lipids, diabetes, and sleep apnea as indicated	Protocol/Process			
Process to share assessment findings and treatment plans with referral source(s) and/or primary care, as appropriate	Protocol/Process			
Transfer of patient information utilizing a standardized method (e.g., discharge summaries) to primary care and other programs or services as applicable	Protocol/Process			
Process to identify whether patient has been reported to the Ministry of Transportation for medical review of driving status, and determine appropriate actions regarding driving concerns as applicable	Protocol/Process	Scroll down to Participation & Life Activities https://cesnstroke.ca/clinical-resources-tools/		
Falls prevention protocol to ensure all persons with stroke are screened for fall risk on admission to service, at all transition points, after a fall, and/or whenever there is a change in health status, and an individualized management plan implemented as needed	Protocol/Process			
The interprofessional team provides patient-centred education based on the assessment of learning needs, level of readiness, stage of care, and patient goals	Protocol/Process			

Theme / Area of Focus	Type	Resource Links	Current State (select based on criteria outlined above)	Notes
Education is interactive, evidence-based, available in a variety of formats and languages, accessible for people with aphasia and/or cognitive deficits or impairments, and considers health literacy	Protocol/Process			
Education plans should: • incorporate stroke care and recovery • facilitate shared decision-making • include teaching of self-management skills • include training of family and caregivers to provide safe stroke care	Protocol/Process			
Process to document education in a health record that is accessible by all members of the healthcare team	Protocol/Process			
Staff utilize Heart and Stroke's "Your Stroke Journey" resource, to support patient education	Standardized Communication	https://www.heartandstroke.ca/-/media/pdf-files/canada/your-stroke-journey/en-your-stroke-journey-v20.ashx?rev=db37bd6d06914138b10f8fe07dd3f06f		
Education promotes self-management and is tailored to individual needs, utilizes teach back strategy & problem-solving approach (e.g. Choices and Changes)	Patient/Family Education	http://www.teachbacktraining.org/home https://www.swselfmanagement.ca/smtoolkit/ **Self Management Programs** NSM https://www.nsmselfmanagement.ca/ Central https://healthy-living-now.ca/ Central East https://www.ceselfmanagement.ca/		
3.0 Community Reintegration Supports: Access to services that facilitate the successful resumption of life roles and activities.				
Process to link patients to resources that support and enable meaningful activities of daily living (e.g. leisure, sexuality, personal care)	Protocol/Process	See Participation & Life Activities https://cesnstroke.ca/clinical-resources-tools/#clinicalresources		
Process to link patients to resources that support return to vocations (school, volunteering, work)	Protocol/Process			
Process to link patient to resources that support return to driving	Protocol/Process			
Process to link patient to community supports & services (e.g. meal provider agencies, accessible transportation, stroke survivor groups)	Protocol/Process	https://www.thehealthline.ca/		
Persons with stroke and families are involved in collaborative decision-making regarding goal setting and transition planning meetings	Protocol/Process			
Information and education is provided on community services that optimize the return to life roles, activities and social participation	Patient/Family Education	https://cesnstroke.ca/clinical-resources-tools/journey-to-recovery/#caregiver		
Central East Stroke Network's "Journey to Recovery After Stroke" resource	Transition Support	https://cesnstroke.ca/clinical-resources-tools/journey-to-recovery/#caregiver		
Heart & Stroke's "Your Stroke Journey" resource	Transition Support	https://www.heartandstroke.ca/-/media/pdf-files/canada/your-stroke-journey/en-your-stroke-journey-v20.ashx?rev=db37bd6d06914138b10f8fe07dd3f06f		
The Healthline	Transition Support	https://www.thehealthline.ca/		

Theme / Area of Focus	Type	Resource Links	Current State (select based on criteria outlined above)	Notes
CESN's Driving Post Stroke Resources	Transition Support	See "Clinical Topics" - "Participation & Life Activities" https://cesnstroke.ca/clinical-resources-tools/#clinicalresources		
Return to Vocation resources	Transition Support			
Peer visiting/support program	Transition Support	https://cesnstroke.ca/professional/wp-content/uploads/sites/2/2021/04/Stroke-Support-Groups.pdf https://www.afterstroke.ca/ https://www.heartandstroke.ca/heart-disease/recovery-and-support/the-power-of-community		
4.0 Specialized Teams & Resources: Access to stroke experts, resources, diagnostic equipment and expertise, and a range of timely and evidence-based treatment options.				
Clients with stroke have access to specialized interprofessional teams in the community, as outlined in Quality Based Procedures for Stroke and Canadian Stroke Best Practice Recommendations	Protocol/Process	See page 93 https://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_stroke.pdf https://www.strokebestpractices.ca/recommendations/stroke-rehabilitation/outpatient-and-community-based-stroke-rehabilitation-including-esd		
Interprofessional teams working in the community (e.g. Home and Community Care Support Services Care Coordinator, allied health, PSW, RN ...) have stroke expertise	Protocol/Process			
Resources to support staff understanding regarding the need for supported transitions and warm handoffs to support integrated stroke care	Protocol/Process	Warm Handoff: Intervention | Agency for Healthcare Research and Quality (ahrq.gov) https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html		
Partnerships and collaboration between primary care, Home & Community Care Support Services, diagnostics, and other community services as appropriate	Protocol/Process			
Process to link staff performance evaluations to Core Competencies	Protocol/Process	https://www.corhealthontario.ca/core-competencies		
Regular meetings of the interprofessional team	Standardized Communication			
Stroke related educational offerings from the stroke networks are disseminated to frontline staff (e.g. workshops and webinars)	Staff Education	See Professional Development Resources https://cesnstroke.ca/professional-development/		
Interprofessional team members are supported to participate in stroke specific development, training, and orientation oportunities as they arise	Staff Education	https://cesnstroke.ca/professional-development/		
Agency utilizes Core Competency Framework with staff to address staff learning needs and a plan is developed to address gaps.	Staff Education	https://cesnstroke.ca/professional-development/#resources		
Canadian Hemispheres 2.0 Stroke Competency Series	Staff Education	https://cesnstroke.ca/professional-development/#resources		

Theme / Area of Focus	Type	Resource Links	Current State (select based on criteria outlined above)	Notes
Supported Conversation for Adults with Aphasia (SCA™)	Staff Education	Supported Conversation for Adults with Aphasia (SCA™) https://www.aphasia.ca/		
Training for the use of Central East Stroke Network's "Journey to Recovery After Stroke" resource	Staff Education	https://cesnstroke.ca/clinical-resources-tools/journey-to-recovery/#caregiver		
Training on standardized validated assessment tools specific to stroke care (e.g. Chedoke McMaster Stroke Assessment, GRASP, CAHAI, …)	Staff Education	See Assessments & Screening > Suggested Screening and Assessment Tools from Canadian Stroke Best Practice Recommendations https://cesnstroke.ca/clinical-resources-tools/ Stroke Engine https://strokengine.ca/en/		
Infrastructure & Governance				
Monitoring and reporting process for rehab referrals and transitions, for system level quality improvement				
Organization ensures that patients and families/caregivers are engaged in relevant processes of care				
Regular review and update of protocols and processes to meet Canadian Stroke Best Practice Recommendations, particularly as new recommendations are released		https://www.strokebestpractices.ca/recommendations		
Mechanisms in place to routinely collect, access and report data to stakeholders				
Program leads participate in Regional Stroke Network(s) system evaluation and performance improvement activities				
Ontario Stroke Reports reviewed and quality improvement plans developed where opportunities for improvement are identified		https://cesnstroke.ca/wp-content/uploads/2021/08/CESN-Stroke-Report-Card-Infographic-2019-20.pdf		
Local performance indicator data reviewed regularly and quality improvement plans developed where opportunities for improvement are identified				
Organization has active representation on Regional Stroke Network related committees as appropriate		https://cesnstroke.ca/about/#		
Participation in Regional Stroke Network initiatives for organizational and cross-system improvement as appropriate		https://cesnstroke.ca/about/#		
Adequate access to staffing to support implementation of best practice care				
Adequate access to resources including equipment and supplies to support implementation of best practice care				
All stroke services and resources are accessible to patients of varying communication, cognitive-perceptual and physical abilities				
All necessary forms, educational materials, and resources are available and easily accessible by all staff				
Organization supports and provides access to translation and interpretation services when required				